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BUFFALO MEDICAL AND SURGICAL JOURNAL.

Established 1845 by AUSTIN FLINT, M. D.

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Associate Editors:

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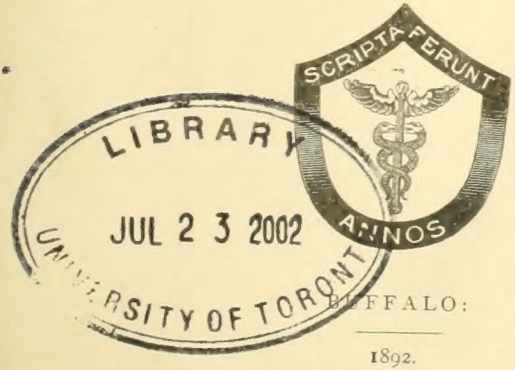
VOL. XXXI.

AUGUST, 1891, TO JULY, 1892.



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Buffalo Medical and Surgical Journal

Vol. XXXI. AUGUST, 1891. No. 1.

Original Communications.

ARTHRECTOMY OF THE KNEE-JOINT.

By HERMAN MYNTER M. D.,

Professor of Operative and Clinical Surgery in Niagara University Medical College.

A SHORT *résumé* of the pathology of tuberculous affections of the knee-joint seems indispensable before discussing arthrectomy, and particularly the importance of the frequency of a local tuberculous focus in the epiphysis. If it should be proved that the majority of these chronic tuberculous joint affections originate from a local focus, there will be no excuse for overlooking and not removing it before the joint has become invaded. The trouble has been that a chronic tuberculous arthritis, whether originating in the bone or in the synovialis, gives, in the later stages, which formerly alone were operated, exactly the same pathological condition. If it starts as a local focus, and perforates into a healthy or partly obliterated joint, a tuberculous arthritis results. The synovialis becomes gradually changed into a tuberculous granulation tissue, the ligaments become softened, the cartilages ulcerated by pressure of the granulations (Volkman's ulcerative decubitus), while, at the same time, the Haversian canals become dilated, and filled with the same granulation tissue, by pressure of which the rest of the cartilages may become shed. And we have then total destruction of the joint, with caries of the epiphysis.

If, on the other hand, it originates as a synovitis, the result is exactly similar,—softening of the ligaments, ulceration of the cartilages, dilatation of the Haversian canals, with shedding of cartilages and caries of the epiphysis. That a carious epiphysis, from whatever cause, may offer a different picture at different points, is well known. Here we may have simply congestion, with

1. Read before the Medical Association of Central and Western New York, in Buffalo, June 2, 1891.

beginning dilatation; there the bone tissue has totally disappeared, and its place been taken by a granulation tissue; in other places we may find necrosis of the granulations from pressure, with formation of little irregular cavities, filled with cheesy pus and bone-spicula; in other places again, larger cavities with sequestra, and whether such a cavity is the original local focus or simply the result of the intense osteitis, it is impossible to decide. We have only one way of finding out, and that is in early operation, and my belief is, that in early operations we will, in almost every case, find a local bone-focus as the cause of the tuberculous arthritis, the prompt removal of which would have prevented the invasion of the joint.

I am aware that, so far, most surgeons disagree on this point.

Watson Cheyne states that, next to the vertebra, the knee-joint is most frequently the seat of tuberculous affections, and that there is a larger proportion of primary synovial disease than in the hip.

Willemin gives the following statistic: Below ten years of age, thirty-nine per cent. were of synovial origin, sixty-one per cent. of osseous origin; from ten to twenty years, forty-nine per cent. synovial, fifty-one per cent. osseous; above twenty years of age, thirty-three per cent. synovial, sixty-five per cent. osseous.

According to this statistic, the osseous origin becomes more prevalent with increasing age, and, consequently, the affections more obstinate. Sequestra were present in nineteen per cent. below ten years of age, in forty-nine per cent. above twenty years of age.

Koenig states that primary osseous and primary synovial diseases are about equally frequent in youth, but in old people osseous three times as frequent.

I can, of course, give no statistic to compare with those of these men, but will simply state, that in every case I have operated I have found a primary osseous lesion. In contrast to the hip, where the local focus most frequently occurs in the neck, the diaphysis, or acetabulum, the epiphysis of the femur and tibia are most frequently the seat of the local focus. Watson Cheyne never found, either in femur or tibia, a deposit beyond the epiphyseal line. The local focus occurs generally at the most exposed parts, and in the neighborhood of points of attachment of tendons and ligaments. The favorite seat is in the lower end of the femur, particularly the internal condyle, thereafter in the head of the tibia, and then

in the patella. Small deposits or local foci are sometimes found immediately beneath the articular cartilages, through which they perforate. The color of the cartilage may indicate the place of the local focus, it being darker and somewhat spotted above it. If the foci are more deeply situated, they may either perforate into the joint or outwards outside the capsule, producing extra-articular abscesses. So much about the pathology. According to the different authors, at least one-half or more of the cases are of osseous origin. I believe that by far the greatest majority commence in this way. I have seen quite a number of early arthrectomies in Europe, and performed the operation a number of times myself, and I have yet to see the first case of synovial origin in childhood. In every case I have seen, a distinct local focus was found.

How, then, ought this disease to be treated ?

The ideal operation is, and would be, to remove the local focus in all cases in which the symptoms point to the formation of such I have lately had the opportunity of seeing two such cases, and will mention them here, as they illustrate the brilliant results of prompt operation and the dangers of delay.

The first patient, George Warner, ten years of age, and of healthy parentage, had a slight injury to his right knee during a visit to St. Louis, in January of this year. I was called to see him ten days later, found him limping slightly with the right foot, looking somewhat pale and peevish, and complaining of starting pains at night. By the objective examination, my first impression was that the knee was healthy, and I looked for symptoms of hip-disease. Finding none, I again carefully examined the knee, noted slight contraction of the hamstring tendons and some atrophy of the calf. Motion was free in the middle-ranges, but somewhat diminished in extreme flexion and extension. The measurement over patella gave one-half inch more than on left knee. On the middle of the lateral aspect of the internal condyle of the femur was found a spot as large as a nickel, on which tapping with the finger produced a most intense, deep-seated pain. The surface thermometer showed a temperature of 101° over this spot. Bodily temperature, 100°; pulse, 96.

I operated on him next day with the assistance of my friends, Drs Parmenter and Smith, trephined the internal condyle, and found the outer part of the bone hyperemic, and, in the center of the internal condyle, one-half inch from the surface, a small cavity as

large as a cherry, filled with pus and tuberculous granulations, but no sequestrum. The cavity was scraped out with a sharp spoon, disinfected with coros. sublim., and plugged with iodoform gauze under an antiseptic dressing. The cavity healed by granulation in about three weeks, and perfect *restitutio ad integrum* followed. Have any of you any doubt that the starting pains at night, and the contraction of the hamstring muscles, indicated that the abscess was near the articular cartilages, and ready to perforate into the joint, and that I, by prompt operation, saved this child from a chronic tuberculous arthritis, with all its possibilities, such as arthrectomy, resection, etc. ?

The patient is present here, and you can satisfy yourselves about the perfect recovery.

The second case, Harold Kurtzman, was that of a little boy, two years of age, whom I saw on February 10, 1891. He had then limped, without known cause, with the left limb for about two weeks. The examination gave about similar results ; some atrophy, slight enlargement over the head of the tibia, while over the internal condyle there was a tender spot, with increased surface temperature, starting pains at night, free motion in the middle-ranges, but slightly diminished extreme extension and flexion. I insisted upon operation, but could not persuade the parents, who consulted two other local surgeons who made light of the matter and merry over my diagnosis, and the patient passed out of my hands into theirs. Dr. Parmenter, who saw the patient with me, agreed with me in regard to diagnosis and treatment. I was called again May 13th, three months later, and learned that, meanwhile, two incisions had been made, during the last of which considerable pus (estimated at four tablespoons) and bone-tissue was removed. In order to make an exact diagnosis, I gave the child chloroform, again in the presence of my friends, Drs. Parmenter and Smith, and found a similar cavity in the head of the tibia as large as, or larger than, a hazelnut, and extending up close to the articular cartilage. I enlarged the opening, scraped the cavity out, and dressed it in a similar way. The child is rapidly recovering.

Have any of you any doubt that this operation might better have been performed three months earlier, and that the delay simply jeopardized the child's health and the functions of its limb ? If we do not get hold of our patients early enough, and more or less destruction of the joint has taken place, we have the choice between resection and arthrectomy, or both. Formerly, the diseased bone

ends were simply removed, the synovialis left intact. The result was anything but favorable. Long lasting suppurations were apt to follow, considerable shortening resulted, which increased during age, on account of the removal of the epiphyseal cartilage. Occasionally no osseous union occurred, and strong flexion was apt to occur from contraction of the flexor-muscles, necessitating, later on, osteotomies or amputation.

Of forty-five resections performed in Copenhagen between 1870 and 1880 (in the antiseptic period), only one had his wound healed by first intention, twelve had some suppuration, thirty-two copious suppuration and abscesses, thirty-one recovered, twelve died, and two were secondarily amputated; but of the thirty-one recovered only one-fifth were without fistulas, and only eighteen gained a fair and useful limb.

A new step forward was occasioned by Volkman and Koenig's statement, that the disease frequently commenced as a local focus in the epiphysis, which, by perforating into the joint, produced the diffuse tuberculous inflammation, unless the joint had become more or less obliterated before the perforation. The former operation—resection—was, therefore, abandoned, and it was acknowledged necessary not only to find and remove the local focus, but the diseased synovial capsule just as well, which formerly had been left, and produced relapses, suppurations, etc. Otherwise the bones were left intact, and the lateral ligaments saved, if possible. This new operation was called arthrectomy, or erasion. But, to succeed well, early operation is necessary, in order not to meet too great destruction, and to avoid universal or local tuberculosis somewhere else. Yet, even after arthrectomy, the results are not always favorable, and a reaction has set in in favor of resection.

It was considered one of the advantages of this new operation that motion occasionally might be preserved, particularly in cases in which the cartilages and lateral ligaments were left intact, and the local focus had been removed without interfering with the articular cartilages.

Some motion, even if limited, would be of advantage in almost every joint in the body, but, as Plum, of Copenhagen, states, it is more than questionable whether motion is desired in the knee-joint or not. Plum has always observed flexion and valgus position of the knee following arthrectomy, and that in spite of all precautions with splints, plaster-of-Paris, etc., he thinks we are able, by either

operation, to remove everything diseased, but that resection alone is able to produce a firm, bony anchylosis, and, therefore, is to be preferred. I do not know but what he is right. I have had the same trouble with the relapsing flexion in pure arthrectomy, and my best results have been in cases in which I, besides the synovial membrane, removed a thin slice of the femur and tibia, and got bony union. I will show you such a case here, which I operated about two years ago. I found an enormous local focus in the internal condyle of the femur, and had to remove the whole condyle. The joint being totally destroyed, the synovial membrane was removed, and a thin slice of bone taken from the denuded tibia and external condyle of the femur. The consulting surgeons present advised, after having seen the condition, that I immediately amputate the leg. Nevertheless, it healed by a moist bloodclot in less than two months without suppuration, and, as you see, he has a good, firm and useful leg.

In another patient, also present here, and operated four months ago, I found a local focus in the internal condyle of the tibia, which had perforated into the joint. I made here a pure arthrectomy, and have had considerable trouble with preventing contraction. She is still obliged to use plaster-of-Paris on that account.

What shall be done with the patella?

If resection is performed, it is of no further use, and may just as well be removed. If arthrectomy pure and simple is done, it is of use, as the extensor quadriceps femoris will, in some measure, counterbalance the flexor muscles. If no local focus should be found, relapses may occur, but as the joint proper has been removed, it will be in the form of an osteitis, and not an arthritis, and the tuberculous granulations are prevented from spreading far and wide.

I do not know that I can finish this short paper in any better way than by adding the conclusions of Ollier, of Lyons, France, as published in the Transactions of the International Medical Congress, held in Copenhagen in 1885, and with most of which I agree:

1. Articular tuberculosis presents a number of clinical varieties which demand a different treatment. Some are curable by arthrectomy or local destruction of the tuberculous products without sacrificing the healthy bone-tissue, others demand the removal of the diseased epiphysis, others, again, amputation.

2. Local, or apparently local, tuberculosis may continue indefinitely as such, and without tending to become general.

3. Conservative operations are indicated in local and circumscribed tuberculosis. The operation to be chosen depends upon the duration and extension of the lesion, the point in question being not to leave behind a focus from which by-and-by a secondary infection may occur

4. Spontaneous recovery of osseous and articular tuberculosis occasionally occurs in infancy and youth by elimination. By surgically removing the tuberculous products, we follow the way indicated by nature. In adults, spontaneous recovery is much more rare, and complications of internal organs much more frequent.

5. Conservative operations are particularly indicated in infancy and youth, and more especially those operations which do not remove the joint cartilage, in order not to interfere with the growth of the bone. Amputations are most often necessary in mature or older age.

6. The surgeon ought always to be guided by the idea of early removing what is necessary, except in tuberculous affections in adults. Here amputation is often preferable.

7. In spite of antiseptics, arthrectomy is a more serious and less efficacious operation than a typical resection, and there is always fear of a local relapse. It is more apt to be followed by general tuberculosis than amputation or resection, by which operations the local foci are removed.

8. The rule to remove all tuberculous products does not apply to simply chronic inflammatory products.

By removing all fibrous tissues around a joint, defective functional results are often obtained.

9. By amputation we prevent best secondary infection of the wound, although even this operation is not absolutely a radical operation, as the deeper and more distant lymphatic glands may have become infected previously. Amputation is particularly indicated in osteo-arthritis of the lower extremity.

10. After a successful resection, when a cicatricial tissue has taken the place of the fungous granulations, the chances of relapse are about the same as after amputation, but the patient has the advantage of having retained his limb.

195 FRANKLIN STREET.

DIARRHEA.—Dispensary prescription:

R—Salol ..... dr. ij.
Bismuthi subnitratis, ... dr. iv.
Mist. cretæ, q. s. ad ..... f. oz. iij.

M. Sig.—One teaspoonful every two hours.

THE CONVERGING LINES OF MEDICAL AND SURGICAL TREATMENT.[1]

By NATHAN JACOBSON, M. D.,
Professor of Clinical Surgery and Laryngology, College of Medicine, Syracuse University, Syracuse, N. Y.

The selection of a general subject as the text of an address implies the presentation of matters which have become trite by frequent repetition. It is not my purpose to laud the special work of the masters of our day, in medicine and surgery, nor to give expression to such optimistic views as did Boyer as long ago as 1814, when, impressed by the achievements of the British surgeons, he wrote: "Surgery seems to have attained the highest degree of perfection of which it is capable."

The first great achievement of the antiseptic era was the perfection of operative procedures and the elimination thereby, in the course of wound repair, of many incidental features which previously had been regarded as unavoidable. Emboldened by the security thus furnished, the surgeon next invaded new territory. New operations were undertaken, and the legitimate field of surgical practice was vastly extended. Cavities of the body, regarded as too sacred for invasion, were opened. Organs formerly considered essential to our economy were removed with impunity. During this antiseptic era, the study of the pathogenic organisms has received new impetus. When, in November, 1875, Robt. Koch brought his cultures of the anthrax bacilli to Breslau, and placed them before Cohn and Cohnheim, the latter, overwhelmed with the importance of his work, and the simplicity, yet exactness, of his methods, prophesied that Koch would yet astonish the world with future discoveries. The verification of the prophecy was not long delayed. With the cultivation of microbes upon solid media, with the isolation of the bacillus of tuberculosis and the specific micro-organisms of other diseases, surgical pathology assumed a new phase, and many of its chapters had to be rewritten. This better appreciation of certain processes has materially changed the relationship of surgeon and physician to each other.

There is, today, no question of greater importance than that which concerns the proper line of limitation of medical and surgical practice. There are diseases running but a brief course, yet so violent and serious as to destroy life within a few days, diseases

1. President's address, delivered at the meeting of the Central New York Medical Association, held at Buffalo, N. Y., June 2, 1891.

which the physician, by sad experience, has learned are entirely beyond the reach of medical aid, but which now, with a better conception of their pathology, are, if seen sufficiently early, often stayed by surgical procedures. There is another class, not of this fulminating type, but which pursues a chronic course, persistently eludes medicinal treatment, and which should be relegated to the surgeon's care. The invasion of the cranial cavity, in the pre-antiseptic era, was much dreaded because of the resulting inflammatory reaction which so often terminated fatally. While Lister was working in the wards of the Glasgow Royal Infirmary, establishing the principles of the proper treatment of wounds in other parts of the body, an earnest colleague, William Macewen, showed that cranial injuries, and, indeed, extensive cerebral wounds, kept aseptic, were quite as amenable to treatment. With the discovery by Broca that a particular area of the brain was the center of articular language, the misconception that the brain performed its duties as a whole, as do the kidneys or the liver, was made apparent. With the growing knowledge of cerebral localization, and the protection afforded by modern surgery, the brain no longer remains a *noli me tangere*. Extensive physiological study and surgical advancement have been required to establish the claim of the surgeon to treat many brain affections heretofore considered the exclusive property of the physician.

These cases demand the careful study of both physician and surgeon. The former may regard in a more hopeful light the outcome of a surgical procedure, which he may believe warranted, than the latter, who recognizes more thoroughly its real dangers. V. Bergman says that in the field of brain surgery, it has occurred to him more than once to be requested by colleagues of rare ability to perform operations which he has been obliged to decline. And so he published his recent work, not, as he says, to extend its domain, but rather to place upon it the necessary restrictions which his experience has taught him should be imposed. While Keen says that any lesion which produces intracranial pressure, which unrelieved would prove fatal, which can be localized and differentiated with reasonable certainty, granted it be accessible, should be removed, my experience has taught me that before deciding upon operation we must determine quite as certainly that the condition is within the reach of surgical relief. I am satisfied that the field of brain surgery demands the most judicious kind of conservatism. With the appreciation of the brilliant achievements

on either side of the Atlantic, must be remembered some very disastrous failures, some of the saddest mistakes in diagnosis, and, consequently, treatment, which could possibly have been made. And so, while we recognize today that many clinical pictures have in the past been misinterpreted, and while we know that cerebral hemorrhage will not be controlled by medicinal agents, that pus will not be spontaneously evacuated from the cranial cavity, that the pressure symptoms occasioned by tumors will not cease while the growth remains, it is essential that the physician and surgeon should act in concert, and, having exhausted the influence of medication in suitable cases, resort to surgical aid only when satisfied that the condition is removable by, and only by, operation. As to the mutual relationship of physician and surgeon in that class of functional disturbances of the brain which endanger life, retard mental development, and destroy comfort and usefulness, I shall make no reference, as this subject has been entrusted to abler hands, from whom we will hear during this session.

In an article which appeared in the *Deutsche Medicinische Wochenschrift*, in January of the current year, Lembke makes the bold assertion that cases of exophthalmic goitre should be admitted to the surgical, and not to the medical, wards of a hospital. He was led to this conclusion, having operated two patients presenting the most serious symptoms possible of this affection, in both of whom favorable results followed extirpation of the goitre. This position is held by very few surgeons. Even Billroth objects to the removal of the entire gland, believing that it often occasions tetanus, and that it is difficult to avoid section of the recurrent nerve. Yet recent investigations show that some, if not all, symptoms are due to functional derangement of the thyroid. Indeed, in some cases the serious symptoms have disappeared, sometimes permanently and again temporarily, after minor operations upon the gland. When life is endangered by suffocation, when distressing symptoms exist which refuse to yield to medicinal treatment, there seems good reason to look for relief from operative measures. The treatment of acute pleuritic effusion is a subject over which there no longer can be any dispute. It has been my experience, I believe that I can say unexceptionally, to find prompt and permanent recoveries after aspiration. As soon as a serous effusion is diagnosticated, be it acute or chronic, it should be withdrawn. The very fact that most of these cases are of tubercular origin, it seems to me, emphasizes the necessity of this procedure.

The fever rapidly subsides, and the danger of subsequent pulmonary disease is greatly lessened. Purulent collections in the pleural cavity are now referred to the surgeon for treatment, but it is frequently a matter of great regret that their recognition comes so late. Great as has been the relief of empyema by simple incision, with or without subsequent drainage, or by resection of the ribs, as occasion demands, the surgical treatment of pulmonary diseases has not been so satisfactory. The greater dangers, the bolder procedures required, and above all the uncertain limitation of the diseases with the still more uncertain outcome of operative interference, has not led to the general adoption of pneumonotomy for draining pulmonary cavities, not to say anything of the more serious operation of pneumonectomy. The most favorable cases of pulmonary abscess for surgical treatment, Mr. Godlee thinks, are those due to pulmonary gangrene.

Before the surgeon can establish his claim to the treatment of these cases, better results must be obtained than appears in the table prepared by Bull, of Norway. In twenty-six cases of lung abscess collected by him and treated by incision and drainage, but four were cured and six improved, while of the others it is said that nine were relieved (these could not have been much improved, or they would have been classed with the other six) and seven were not benefited by operation.

The affections of no part of the body bring the physician and surgeon together more frequently than do those of the abdominal cavity. Some develop slowly, while others are of such an acute character that they threaten life from their very onset. T. Gaillard Thomas, in an able essay a few years ago, brought to the notice of the profession the fact that ascites many times appeared in women, as the result of pathological conditions, entirely removable by surgical procedures. Often it is a small growth mischievous by its compression, again a tubercular peritonitis.

Hepatic and biliary disturbances, when amenable to operative treatment, have yielded many times brilliant results. It does not seem to me that the dangers of obstruction by biliary concretions are sufficiently recognized by the general practitioner. Many times, and Harley says in the majority of cases terminating fatally, there has been neither jaundice nor paroxysmal pain. There is no doubt that each year many lives are sacrificed either because the impacted concretions remain unremoved, or ulcerating through the gall bladder or ducts produce fatal hemorrhage or peritonitis. The recom-

mendation to knead the distended bladder and force its contents into the intestines, seems to me, may lead to serious trouble.

It is, however, the acute abdominal disturbances, obstructive, inflammatory and perforative, which require from their beginning the united attention of physician and surgeon. These troubles present themselves with such suddenness, and yet with symptoms which do obscure their real nature, that many times it may be questioned whether, when their diagnosis can be made with sufficient certainty, the favorable moment for operation has not passed. The technique of abdominal operations has been so thoroughly perfected that fear of entering this cavity has substantially disappeared. Not so much can be said for the differential diagnosis of acute intestinal obstruction. Yet, even here the past two years have witnessed a marked advance.

On the evening of April 21, 1889, I saw, with Drs. Heffron and Totman, of Syracuse, a babe five months old being nursed by its mother. On the morning of this date he was suddenly seized with severe colic, vomiting, and the rectal discharge of blood-stained mucus. Dr. Heffron discovered at his first visit a tumor in the right iliac region; no fever. Intussusception was diagnosticated. A large quantity of water was carried well up into the colon through a long rubber tube, and the tumor apparently disappeared, but the vomiting after each nursing and the bloody discharge from the rectum continued. The child cried incessantly. At our consultation in the evening the tumor was again found to be present and more elongated than before. The abdomen was very rigid. This time under chloroform the colon was distended with water, the child inverted, the intestines kneaded. The tumor again totally disappeared. Opiates were advised, and delay until morning seemed justified, but when the morrow came the condition was extremely grave. The pulse could no longer be counted; temperature, 103 degrees; the tumor was present and exhibited some evidences of crepitation about it. The vomiting had become stercoraceous; the bloody stools persisted, and the child passed rapidly away. The entire period of illness did not exceed thirty hours. At the autopsy the tumor was found to no longer occupy the ileocecal region, but to be located well over towards the splenic flexure of the colon. About twelve inches of large intestine was occupied by small gut, which had dragged up into the colon some of the omentum, as well as a little of the ascending colon. The adhesions between invaginated gut and its receptacle were so firm that no amount of irriga-

tion with whatever degree of force could have secured the reduction. In fact, it was literally impossible to draw out the invaginated mass, and the specimen, as preserved, presents the reduction uneffected. General peritonitis was present. Cases of such acuteness, and at such an early period of life, certainly present but little to encourage an operation, yet without it death is inevitable. The medical journals are not barren of successful operations in really desperate cases. The importance of this subject is apparent, as Treves, in the preface of his work on Intestinal Obstruction, says that over two thousand individuals die annually in England from various forms of obstruction of the bowels exclusive of hernia.

Hatherly, in his presidential address before one of the branches of the British Medical Association in 1888, took the ground that peritonitis was not to be treated by section except it be evident that the disease originated in local mischief. As there is a growing conviction that with but very few exceptions general peritonitis is the outcome of a local disturbance, most cases of inflammation of this structure demand surgical aid.

The classic paper of Fitz, before the Association of American Physicians in 1886, presented, in a remarkably able and comprehensive manner, the pathology of inflammation of the vermiform appendix. The importance of his conclusions cannot be overestimated. It is evident that an appendix once inflamed is a very dangerous tenant to harbor in the body. At the session of the Freie Vereinigung der Chirurgen Berlins, held October 13, 1890, it was made evident that the German surgeons are much more conservative than are we. Israel, for example, restricts operative interference to but a limited class of cases. The claim was made that suppuration occurs infrequently, Gerhardt believing it to be absent in ninety-five per cent. of the cases. Much the larger number, it was stated, recover unoperated. Operation, we are told, exposes the patient to diffuse peritonitis, and, therefore, when no abscess can be felt, we are to await the appearance of grave symptoms, indicating a change for the worse, either a receding temperature, with increasing pallor and mild cyanosis, or a sudden rise of temperature with generalization of pain previously localized, increased vomiting, etc. The autopsies, which can usually be made after operations performed at this period, tell the sad tale that surgical aid has been too long delayed. Three times within the brief period of as many months I have been called to cases of perforative appendicitis complicated with general septic peritonitis, to find the patients entirely beyond

operative relief. It requires no statistical tables, no figuring of percentages, to determine this question. I may have had an unfortunate experience, but it has been my ill-fortune to have never seen a recovery in this type of cases under the opium and rest treatment. When, on the other hand, McBurney presents a list of twenty-four operations done during the past two years for perforative appendicitis, with but a single death, the surgical treatment is most emphatically justified. The one point upon which all turns, is, of course, the early recognition of the trouble. Most of these cases die before the fifth day, which was the earliest period fixed by Willard Parker for operation. Now, we know that the third twelve hours of the sickness is the time to consider surgical treatment. The many able papers presented at the last meeting of our State Society upon this subject, lay down the principles for guidance both in diagnosis and treatment. One point, I believe, cannot be too emphatically stated, and that is the much greater importance of the local symptoms as against the general ones. We depend today too much upon the thermometer in gauging the seriousness of the disease. We are leaning, as it were, too heavily upon a fragile glass staff. Within ten days I had occasion to see during his last hours a young attorney of bright prospects, who throughout his illness of five days had an unvarying temperature of ninety-nine degrees, and yet the autopsy showed, besides the perforation due to a fecal concretion, a most severe septic peritonitis. The pulse is the better indicator of the seriousness of the condition. If we wait until it goes to and above 150, becomes feeble, compressible and flickering, we had better allow our patient to pass away undisturbed by surgical interference.

Successful as has been the early treatment of perforative peritonitis due to typhlitis, the operative treatment of intestinal perforations in typhoid fever has been most unfortunate. I have gone over with considerable care the recent literature of this subject which begins with the case of Luecke, operated in October, 1885, and have collected the records of some eight cases, but have yet to find the report of a single successful operation. The reasons for this sad result are self-evident.

Although I have occupied more of your valuable time than was my intention, I desire to consider another class of cases, usually unrecognized, and to which the surgeon in the light of recent experiences may lay some claim. I refer to primary tuberculosis of the kidney. Primary tuberculosis of the kidney is generally held

to be a very rare affection. I believe it to be of much more frequent occurrence than is ordinarily supposed. Morris speaks of two varieties. In the disseminated form, miliary nodules are scattered through the kidney. This, he says, is usually part of a general malady. The second is a strumous pyelitis. Kuester improved upon the description of the later form by calling it caseous, and described the condition encountered as a yellow, cheesy infiltration in the calices and pelvis of the kidney. If this substance be scratched away the membrane is found to be ulcerated, and in the ulcer numerous gray granules are scattered.

To illustrate the clinical history, as well as the pathology of the disease, permit me to report a case :

F. B., *æt.* 25, married, grocery clerk, father died *æt.* 45, of consumption, otherwise family history clear ; referred to me by Dr. J. H. Coe, of Syracuse; admitted to St. Joseph's Hospital, February 1, 1891; never had had any venereal disease. Enjoyed good health until one year prior to admission into hospital. At this time urination became painful and frequent. The right lumbar region was the seat of much pain. These symptoms steadily increased in severity. He became exhausted after very slight exertion. Pain extended down to the right testicle ; at first paroxysmal, it soon became constant ; sometimes it would extend down the right leg. Beginning with November, 1890, each urination was attended with pain through the penis and at the glans. He reported that on December 1, 1890, he passed a stone one half the size of a pea. This was followed by two more, at intervals, of a week. The last was attended with quite a little hemorrhage. No physician ever saw the so-called calculi, and in the light of what is now known of the case, I think it probable that they were cheesy masses. From this date until his admission into the hospital, his suffering was severe and constant. The desire to urinate obliged him to expel the bladder contents every fifteen minutes, day and night. Some days he suffered intensely. There never was any pain in the left lumbar region, nor along the left ureter. No concretions were discharged while under my care. The urine was frequently analyzed, and it was found usually to be alkaline, with sp. gr. varying from 1008 to 1015, always albuminous, no casts, and though frequently sought for, no bacilli of tuberculosis were found, except in the urine discharged the day before operation. The urine persistently presented a stringy sediment upon standing, while the supernatant fluid remained clear. The morning temperature was, as a rule, normal. Each evening it rose to or above 100 degrees F. He was pale, lost some in flesh, and was growing constantly weaker. He had no cough nor other symptoms suggesting disease of the respiratory organs. Manipulation of the right lumbar region would always greatly aggravate his suffering.

that of the left produced no disturbance. Physical examination: The urethra was clear and patent. The right lobe of the prostate was smaller than the left; both very firm. The sound revealed nothing abnormal in the bladder. Under ether, careful search for a tumor in the lumbar region failed to reveal any abnormal growth. The kidney could not be made out by palpation. February 20th, with Dr. H. L. Elsner, of Syracuse, the bladder was examined with the Leiter cystoscope. A slightly darkened area at the opening of the right ureter was the only abnormality apparent. The patient grew steadily worse. His suffering was so severe that he insisted that death would be preferable to his present condition, and implored me to relieve him by operation, if possible. I decided to do nephrectomy. The lumbar operation was performed March 23, 1891, with the assistance of the staff of St. Joseph's Hospital. When the kidney came into sight, its surface was found to be studded with small hard tubercular masses. The removal of the organ was quite difficult, as it was extremely long, reached well under the ribs, and tapered above to a point. Moreover, it was very friable, and was torn in the effort to remove it. Its capsule was also stripped off in its removal. The cavity was packed with iodoform gauze. Reaction was quite sharp; cystitis developed. The urine at first reduced greatly in quantity, reached the normal amount about the third day, but became very ammoniacal. By this time the general condition had decidedly improved, and the cystitis was really the only condition requiring much attention.

I will not delay you with a history of the case since the operation, more than to say that for the first month he steadily improved and was able at this time to be dressed and sit up during a part of each day. Since then his condition, however, has not been satisfactory. He does not gain strength nor weight, although his appetite is excellent. He still has an evening rise of temperature. He is not obliged to urinate oftener than once in two or three hours, and suffers no pain whatsoever. The urine examined on May 30th was found to be light yellow in color, some viscid sediment upon standing; sp. gr. 1012 alkaline, a small amount of albumin and a few bacilli present. I present to you the kidney for inspection. It is 5½ inches in length, 2½ inches in width, and 1½ inches in thickness. Its surface is studded with millet-seed tubercles, especially marked at the upper pole. The cut surface is pale, the cortex swollen and granular. The calices contain gray ulcerations covered with cheesy pus. The ulceration is very marked just below the outlet of the pelvis.

Dr. Sears, pathologist to the hospital, made the microscopical examination. He reports that the cheesy masses contain great

numbers of bacilli of tuberculosis. Thin sections of the kidney were found to contain a few bacilli, most numerous near the seat of ulceration, but extending up the straight collecting tubules. In other sections, the epithelium of the convoluted tubules was seen to be swollen, granular, in many places detached. The tubules situated in the pyramids of Ferrein showed less destruction of epithelium. The Malpighian tufts nearly filled the capsules of Bowman.

This case brings up the question of diagnosis and treatment of primary renal tuberculosis. The specimen presented, it seems to me, strongly suggests that the so-called two forms of tubercular disease of the kidney are in reality but different stages of one, or at least may coëxist. When the pelvis of the kidney is the seat of tubercular degeneration, and cheesy particles are carried off with the urine, the diagnosis upon microscopical examination should be much more readily made than when the tubercular deposit is in the cortical substance. The chemical examination of the urine will reveal a low specific gravity, acid or alkaline reaction and the presence of a small amount of albumin. If the microscopic examination rests with a search for casts and urinary deposits, evidently the true nature of the disease will remain undiscovered. Rovsing, of Copenhagen, in a recent work upon bladder inflammations, takes the advanced ground that no urinary analysis is complete without its bacteriological examination. The bacilli in urine can be discovered by the Ehrlich method. They are found to be very slender and somewhat elongated. They cannot be discovered in ammoniacal urine, as the bacilli then fail to take the stain. The character of the urine must be corrected not by the addition of chemicals to it after its discharge, but by the administration of suitable drugs to the patient. Sometimes it is wise to pursue the method of v. Bergman, who advises that the bladder be first irrigated, and, when cleansed, the kidney is to be kneaded and its contents forced into the bladder. The catheter is now again introduced and the discharge thus gained carefully studied.

The suggestion appeared a few weeks ago in the *Centralblatt für Chirurgie*, (Emil de Vos. No. 18, 1891,) that pure egg albumen be added to four times its weight of distilled water. A precipitate settles to the bottom of the tube and 10 c. c. of suspected urine is added to the supernatant fluid, thoroughly shaken and heated in a water bath at 150–160 degrees F. to its coagulation. If the urine contains much albumen, it requires simple boiling. Allowing it to stand, the bacilli are more readily found in the sediment precipitated.

But however examined, the finding of the tubercular bacilli in the urine is pathognomonic. Very often the bacilli are not discovered, and then our diagnosis cannot be as positively made. Palpation, in our case and in many others, by whatever method practised, is often disappointing. Where the healthy kidney has, because of its increased labor, become hypertrophied, in at least one case, a mistake occurred in determining which was the diseased organ. When the symptoms suggest disease of a kidney and the diagnosis lies between tuberculosis, stone and beginning tumor, abdominal section has been advised and undertaken by Tait, Thornton and others, for the purpose of determining the condition of both kidneys, and of performing nephrectomy at the same time if it is deemed advisable. The cystoscope will, no doubt, prove of great service in deciding as to the absence of tubercular cystitis, the limitation of disease to a single kidney and to which one, by observing the character of the urine spurting from each ureter, and also that very important question as to whether there is a second kidney, that the removal of the only existing organ may be prevented. The temperature should be closely studied ; daily exacerbation in a doubtful case is very suggestive. When primary renal tuberculosis has been diagnosticated, and the other organs have been found to be free from disease, when it is rapidly progressive and the patient's life is made unendurable by his suffering, with no outlook for any improvement, the question of operative interference must be considered.

Surgical literature is not rich in nephrectomies done for this affection, and the question as to its advisability is still an open one. If done at all, it should be performed early, and just here comes in the difficulty of its early recognition. Kuester diagnosticated the disease in one patient where it had existed but eight weeks. The danger of dying later of tuberculosis of some other organ, the possibility, or rather probability, that the other kidney is diseased, render the operation anything but hopeful, and yet Martin reported a case in which the patient was alive and well eight years after operation, and successful cases were reported by Madelung, Koenig, v. Bergman, Israel, Miculicz and others, at the German Surgical Congress of 1890. But I am occupying too much time. Many valuable contributions are awaiting a hearing. It is evident, however, that the relations of physician and surgeon have decidedly changed during the last decade. There exist in almost every region of the body affections which demand the careful, earnest study of both, and only by this coöperation can we reach a conclusion as to the

proper limits of medical and surgical treatment. No doubt, many surgical procedures now undertaken will be found involving too great danger with too little promise of benefit, and will, therefore, be abandoned, while other affections even now considered hopeless will be relieved by surgical measures. We are passing through a most critical period, and the good judgment of the profession will be greatly taxed in carefully analyzing the results of medical and surgical treatment, and in selecting that which is for the best.

NECROSIS OF THE RIBS, COMPLICATING POTT'S DISEASE.

By LOUIS A. WEIGEL, M.D., Rochester, N.Y.

Orthopedic Surgeon to the Free Out-Patient Department of the Rochester City Hospital.

NECROSIS of the ribs, as a complication of Pott's disease, is sufficiently rare to merit record. The following case is of interest, as an illustration of this unusual complication:

Rebecca R., colored, æt. twenty-eight years, gives a history of an injury dating back about nine years, when she fell on the ice and wrenched her back. Previous to the injury, she states, her back was always weak, and she had a lateral curvature of the spine. Some time after the injury, a kyphotic prominence of the seventh and eighth dorsal spines showed itself, which was treated with plaster-of-Paris jackets for about two years. While under treatment her general health improved, and she was more free from pain. Soon after discontinuing the jacket treatment, an abscess appeared in the lumbar region; but after repeated aspiration she finally recovered from this. She now remained in fair health for about five years, during this time, however, the antero-posterior curvature gradually increased. In January, 1889, an abscess appeared in the left dorsal chest, just below the scapula, which was opened. On May 11, 1889, she was admitted to the Rochester City Hospital as a medical patient. At that time she had a distressing cough, profuse purulent expectoration, night sweats, etc. The dorsal abscess was discharging very profusely, and she suffered considerable pain in the back. Under treatment she improved in general health, but the condition of her back remained unchanged.

She came under my care in July, 1889. As she was unwilling to remain in the hospital, she was made an out-patient in August, 1889. The abscess was treated by irrigation and iodoform tents. The discharge of pus, however, continued to be very profuse, and she again began to fail in health. As it was evident that the pus

1. Read before the Medical Society of the State of New York, Feb. 3, 1891.

proceeded from diseased bone, which was readily detected by probing, she was induced to re-enter the hospital for the purpose of operative interference, October 21, 1890. Operation October 24, 1890. An incision, about five inches long, was made, extending nearly horizontal from the orifice of the old sinus. With a cross incision the ribs were fully exposed, and the eighth rib found to be extensively diseased. The articular extremity of this rib was nearly detached from the vertebra, the articulation being completely disorganized by the necrotic process. Upon examining the surrounding structures it was found that the sixth and seventh ribs were also diseased. The lower border of these two ribs was serrated and undermined, the disease being more extensive on the anterior than on the posterior surface. To the left of, and parallel with, the spinal column, a sinus extended downward about four inches. This was, probably, the remains of the lumbar abscess. The necrotic portion of the eighth rib was carefully detached from the underlying structures and resected. The carious portions of the sixth and seventh ribs were removed with gouge forceps, a drainage-tube inserted, and an antiseptic dressing applied.

There was no marked reaction following the operation. There is nothing specially to be noted in the subsequent course of the case, except that the pulse remains comparatively rapid, which condition existed previous to the operation. The pulse fluctuates between 90 and 130. The temperature after the operation showed no regularity in its rise and fall. The highest evening temperature is recorded on the twelfth day after the operation, when it reached 102.6°. The respiration is accelerated, which might be expected in a patient whose thorax is greatly deformed and distorted.

Since the operation, the patient's general health has greatly improved, and she expresses herself as feeling better than she has for months before. Her pulse yesterday A. M. was 90 ; temperature, normal. For some time after the operation, the discharge of pus was quite profuse, but within the past month it has greatly diminished in quantity.

When abscesses occur in the course of Pott's disease, they usually follow the line of least resistance, and manifest themselves in the lumbar, iliac, or psoas regions. Even when the tubercular disease exists in the transverse processes, which lie posterior to the ribs, it is uncommon for an abscess to appear in the lateral dorsal region ; and hence infection of surrounding structures is not likely to occur.

In the case reported, the disease of the ribs was, undoubtedly, secondary to the caries of the dorsal vertebræ, due to an extension of the tubercular process by continuity of structure. This would be a reasonable assumption, at least, with reference to the eighth rib. But the carious condition of the fifth and sixth ribs, at a point quite remote from the seat of disease in the spine, cannot be explained in this way.

Opinions differ as to the advisability of operative interference with the abscess, and resection of the ribs. Thus Albert[1] says he has never seen the slightest favorable influence upon the carious process follow an operation, and believes that opening an abscess occasionally hastens a fatal result. With reference to resection, he admits that not a few cases of cure are recorded; but is inclined to think that the favorable ones only are published. He has operated but twice, and failed to get a recovery, or even an improvement in the general condition of the patient. Both of his patients subsequently died of phthisis.

Israel[2] reports a case, in which he resected a portion of the twelfth rib, and scraped out the carious portion of the diseased vertebral body, in a patient thirty-four years of age. The patient did well for five weeks, when an empyema resulted, and death followed.

Notwithstanding these unfavorable opinions, the justifiability of operative interference, in cases similar to the one reported, seems to me to be beyond question.

[Note.—The patient was discharged from the hospital, convalescent, April 29, 1891. The amount of pus discharged is very small, the patient has gained about fifteen pounds in weight, and is in excellent general condition.]

54 N. Clinton Street.

Asthma Powder.—

R—Pulv. stramonii fol.	32	grammes.
Pulv. belladonnæ fol.,	32	"
Pulv. potass. nit.,	4	"
Pulv. opii,	1	gramme.

Burn a little and inhale the fumes.

1. Albert, Chirurgie, Bd. 2, p. 174.
2. Bradford & Lovett, Orthop. Surg., p. 96.

Society Proceedings.

NEW YORK ACADEMY OF MEDICINE. — SECTION ON ORTHOPEDIC SURGERY.

Stated Meeting, May 15, 1891.

Samuel Ketch, M. D., Chairman.

Dr. T. Halsted Myers presented a case of marked rickets, called congenital on the mother's positive assertion that the greatly enlarged epiphyses of the tibia, femora, and radii were present when she first examined the child a few days after birth. The sternum at that time, she noted, also was abnormally prominent. She had been in very good health all through gestation, and the father was a healthy man. No specific history could be obtained.

At present the child is six years of age, and presents all the deformities of rickets in a marked degree, except that the head is well shaped, and there is a marked increase of the normal dorsal curve of the spine, rather than the dorso-lumbar kyphosis usually found in these cases. An unusual degree of permanent knee and hip flexion also exists, and the patient assumes, when resting, the hand-to-knee position of Pott's disease. The epiphyseal tenderness present seemed to indicate an active stage of the disease. After being nursed nine months, the child had a mixed diet, not especially starchy, nor lacking in animal fats.

The Chairman thought it not improbable that the spinal symptoms were the result of an acute lesion occurring coincidently with this diathesis. In cases of simple kyphosis which he had examined, one of the points in the differential diagnosis had been the absence of psoas contraction, and in most of these cases the curve, unlike this one, disappeared when the patient was in the prone position.

Dr. John Ridlon exhibited the photograph of a patient, nineteen years old, who had had exactly this position all his life. There were additional curves in both the tibia and femora, which had developed gradually during his growth. It was worthy of note that psoas contraction was also present in his case.

Dr. Newton M. Shaffer had seen psoas contraction in these cases of rachitis. The case just presented was not, in his opinion, one of tubercular disease of the spine, but a sensitive condition of the cancellous structure in the bodies of the vertebræ which simu-

lates Pott's disease. He had never seen a case which he could consider one of congenital rachitis, and he was inclined to look upon this one as an instance of rachitis acquired at a very early age. It was not uncommon to find in rachitic patients a condition of the muscles somewhat resembling that found in tubercular joints. He was reminded of a case which he had seen in St. Luke's Hospital, in which there was a very sensitive joint, associated with muscular symptoms which might suggest hip-joint disease, but these were simply due to hyperemia of the epiphysis occurring in a rachitic subject, and in due time, with proper attention to nutrition, these symptoms disappeared.

Dr. Ridlon said that he had expected to present a patient illustrating certain peculiar conditions found in persons who had the caisson disease. His patient had been working in compressed air for sixteen years, and during the past year had had forty or more attacks of the cramps which are peculiar to this disease. Associated with these were stiffness, gradual shortening, and outward rotation of the right lower extremity, with a direct upward dislocation of the hip for a distance of three-quarters of an inch. This man had informed him that he knew of a number of others who had been working in compressed air, who had paralysis with shortening of the limb.

The Chairman said that he had seen a man, forty years of age, who had been a caisson worker and diver, and who presented an affection of both hips. There was very little motion except in abduction. There was no history of rheumatism, or other constitutional disorder.

Dr. Shaffer had recently seen, at the Orthopedic Dispensary, a caisson worker, who presented bilateral hip symptoms, and who was scarcely able to walk. In this case, the symptoms were those of a pronounced rheumatic type, and the changes were apparently due to rheumatic arthritis.

Dr. Ridlon also exhibited photographs of the latest modification of Grattan's osteoclast, and of some of the cases which this surgeon had treated by means of the instrument. He now used it for forcibly correcting club-feet, and in the opinion of the speaker it was the handiest and most efficient contrivance of its class that he had seen.

NON-UNION AFTER OSTEOTOMY IN A CASE OF SEVERE RACHITIS.

The Chairman presented a little girl with a very exaggerated form of rickets, whose symptoms indicated that the disease was still active. The chief point of interest was the fact that, about three years before, a skilful surgeon had performed osteotomy upon her for the correction of a severe form of bow-legs, and this had resulted in non-union. This case showed the folly of operating in the presence of such a virulent form of rachitis. The treatment, in his hands, had consisted in the application of a co-aptation splint, and of a perineal crutch, which, by means of a snap-joint, allowed motion at the knee, but prevented dangerous traumatism, and favored locomotion. The idea of the apparatus was to favor locomotion rather than to attempt to secure union.

Dr. Royal Whitman doubted if this treatment would lead to union of the fragments, for the end of the bones, in such cases, become extremely hard, and usually require to be removed before union can be secured.

Dr. R. H. Sayre thought the non-union, in this case, might have resulted from the fact that the deformity was so great that, in order to correct it, a considerable interval must have been left between the ends of the bone after the osteotomy.

WHEN SHALL WE DISCONTINUE MECHANICAL TREATMENT IN HIP-JOINT DISEASE? WITH REMARKS ON THE SYMPTOMS AND TREATMENT.

The paper of the evening, bearing the above title, was read by Dr. Newton M. Shaffer.

The writer called attention to the difficulty which often existed in deciding this question, and entered a strong protest against the use of an anesthetic as an aid in reaching a conclusion. Ether, it was claimed, would remove the reflex muscular protection of the joint in osteitic disease, and, with nature's protection removed, undue traumatism might be inflicted, and under the influence of this traumatism, encysted tubercular material might be broken up and a fresh infection occur. He recognized the fact that tubercular disease must run a long course, and he had long since ceased to expect any "short cut" in the treatment of these conditions. Scientific mechanical treatment places the joint under the best local conditions for repair, and aids nature, by climatic and other influences, in reaching the period of self-limitation; but, after disintegration of the joint had once occurred, there was no apparatus that would cure hip disease, any more than a splint would cure a fractured

thigh. Reference was made to the report by Dr. Lovett and the author on The Ultimate Results of the Mechanical Treatment in Hip-Joint Disease, published in 1887. Notwithstanding the great care exercised, and the four years' limit which governed the investigation of the cases reported upon, there had been several relapses.

Attention was then called to the fact that many surgeons ignore the neuro-muscular symptoms of hip-joint disease, and to the fact that anesthesia removes the true reflex muscular spasm; that the absence of pain was not a safe criterion; that the absence of abscess afforded no positive evidence of the cessation of the disease; and that the patient could stand a very severe concussion of the joint without pain or flinching, and yet be suffering from extensive and progressive tubercular disease; that abscesses and sinuses might exist (unconnected with the joint), and yet the patient be free from the necessity of mechanical treatment; and that sinuses might close, and abscesses disappear, with active disease present.

The author then stated that only two elements existed upon which a positive opinion could be based, viz.: (1) the gait and attitude of the patient, and (2) the character of the resistance to joint motion thus obtained. He divided the limp into three classes: (1) the limp of true disease; (2) the limp of a vulnerable joint in the convalescent stage, and (3) the limp of shortening and disease, all of which were described.

The important element, however, was the neuro-muscular protection of the articulation. He described it as a purely involuntary and instinctive effort on the part of nature to prevent traumatism. Without this element present, we are unable, as a rule, to make a diagnosis of hip disease, and if it were not present there would be no deformity. The mechanical treatment should be directed not only to the deformity, but to the disease; and the necessity of controlling the knee was pointed out. The author's experience led him to advise the use of the old Taylor traction splint, with the rigid pelvic band, and double perineal pad, in securing the proper modification of traumatism at the hip, and in controlling the knee; and he spoke rather disparagingly of any splint in the state of convalescence which permitted motion at the knee. He also stated that we need not fear the effect of prolonged mechanical treatment as much as the unheeded cry of the diseased joint for proper protection.

The following conditions contra-indicated the removal of the apparatus; if manual concussion produces pain or flinching; if

there is considerable deformity without anchylosis: if there is a true joint limp, or if there are abscesses or sinuses connected with the joint; or if there is a true reflex; muscular spasm limiting movement slightly in all directions; if there is almost perfect flexion, with the other movements considerbly or markedly limited; if flexion and abduction and adduction are excellent, with rotation and extension limited; and, finally, if all the movements are nearly normal, except rotation inward during flexion (the limitations being due to the neuro-muscular protection), it is not safe to discontinue mechanical protection. Rotation inward during flexion is always the last motion to recover, and this may remain for several years after all the other signs have disappeared, and, in many cases, it still remains after the joint had recovered; but, in the latter case, its reflex character disappears.

Attention was called to the fact that, even after the limp had entirely disappeared, a relapse may occur. A recent case, occurring at St. Luke's Hospital, was cited as an example. From this and other similar cases, the author draws the conclusion that there is a recognizable stage of hip-joint disease which ante-dates the limping stage.

Excising the joint was then referred to, and the conclusion reached that in the absence of signs and symptoms by which we can exactly determine the extent of the lesion, and with the great difficulty, not to say impossibility, of a complete excision of the acetabular portion of the joint, excision of the joint was an unsatisfactory and, in many cases, an unsafe operation, and that mechanical treatment, while more difficult, and requiring special training to make it successful, promised more satisfactory results, both as to life and usefulness of the affected member.

The conclusions were as follows:

In the first apparent stage of tubercular disease of the hip-joint, when there is no deformity present, and where we have only the neuro-muscular signs or the slight limp, or both, to guide us, as well as in the more severe forms of the disease, where tubercular disintegration of the joint had commenced, and when the muscular protection of the articulation is more pronounced, the only safe guides for discontinuing mechanical treatment are (1) the absence of the expressive attitude and gait of tubercular osteitis of the hip-joint, and (2) an essential modification or an abolition of the instinctive neuro-muscular protection of the

articulation; (3) that in all but exceptional cases a relapse as to the deformity, or the disease, or both, is likely to occur as the result of the traumatism of locomotion, unless proper mechanical protection is maintained until the articulation is free from true reflex muscular spasm, or is anchylosed.

DISCUSSION.

Dr. A. B. Judson shared in the general wish for more certain indications in the convalescent period. He agreed with Dr. Shaffer in thinking that the reflex or neuro-muscular signs are by far the most valuable indications of the condition of the joint. He never resorted to the use of ether in examining the joint, or to the more atrocious barbarism of striking the patient's heel till pain is produced. A patient of his had described the sensation of reflex action by saying that it resembles the general sensation felt in a swing when the descent from the highest point begins.

As but few of the superficial muscles are found by palpation to be contracted, he thought it likely that the intrinsic muscles, those beyond the reach of palpation, are chiefly affected, and suggested that, probably, the muscles exhibiting those phenomena are those which, like the adductors, have their origin and insertion in the bones which enter directly into the composition of the joint. The patient or the mother is sometimes alarmed by the discovery of the rigid adductor muscle, which is thought to be a morbid growth, or an abnormal bone, till it is shown that a similar thing is produced on the well side when an effort is made which throws the adductors of that side into tonic contraction.

He thought it well to note the variety of these reflexes. Fixation of the joint is produced by a tonic contraction, but motion, especially in the early and convalescing periods, is asserted at a varying point when a considerable arc has been traversed, by a muscular spasm often recognized by the patient. Dr. Fayette Taylor, observing with still greater refinement, had classed "reluctance to relax," shown by the circumarticular muscles, among the reflex signs of incipient osteitis.

Dr. R. H. Sayre said that if the signs of reflex spasm continued, there was but little doubt that an unprotected joint would become deformed. An experimental removal of the apparatus seemed to be the only way of deciding about discontinuing mechanical treatment. It was true that the late Mr. Thomas said that anyone who could not tell the day and hour when the disease

stopped, ought not to treat joint diseases; but his remarkable insight would appear to be quite exceptional. The existence of internal rotation and flexion he did not consider to be so significant as the author stated, for a hip which recovered with impaired motion was not necessarily a vulnerable one. It was highly important to distinguish carefully between the limitation of motion resulting from a deposit around the joint, and that due to reflex spasm. In the former, there was not likely to be any damage to the joint from the removal of protecting apparatus.

Dr. Whitman thought the case cited in the paper, which proved fatal as a result of prolonged suppuration, should have been treated by excision, for he had seen a number of apparently hopeless cases of this kind recover after such an operation.

Dr. H. W. Berg thought that reflex muscular spasm was an unconscious as well as a conservative effort of nature, and, therefore, he could not understand how a description could be given by Dr. Judson's patient of the sensation produced by this spasm.

Dr. Judson replied that the reflex action in question, when spasmodic, resembles the ordinary reflexes, such as respiration and nictitation, in being recognized by the patient.

Dr. Myers said that the case at St. Luke's Hospital, referred to, had been examined repeatedly for six weeks after all pain, deformity, and limp had disappeared, and the reflex muscular spasm was always detected. He had found the suggestion of Dr. Shaffer to carefully avoid outward rotation during flexion tests, a very practical and valuable one, and had also noted that the same care should be used in testing abduction to avoid outward rotation, as the reflex muscular spasm at times could only be detected at the very extremes of motion. Dr. Myers said that during his observation of hip joint disease under the tuberculin treatment at St. Luke's Hospital, he had made daily careful examination, and had come to the conclusion that the reflex muscular spasm was the first symptom affected. In the more marked cases, the symptoms, though lasting but a few days, exactly resembled the usual exacerbation of the disease, with increase of reflex spasm, less motion, or even deformity, increase of pain and sensitiveness, and recurrence of night cries. In less marked reactions, several times the reflex muscular spasm become more alert, though there was no rise of temperature, nor appreciable increase of joint sensitiveness, or decrease of motion. He believed with the reader of the paper, that

this spasm was the first and the last symptom in hip-joint disease. The tubercular process, he thought, was self-limited, and, therefore, the indication to avoid traumatic reinfection was imperative.

Dr. Samuel Lloyd referred to a case of hip-joint disease, which he had had under observation, in which there was a recurrence after a period of nearly nine years. The proper time for the removal of apparatus could only be determined by experiment in each case. Lately he had been endeavoring to assist the mechanical treatment of suppurative cases by injecting a ten per cent. emulsion of iodoform in glycerine, and the results so far had been quite beneficial.

The Chairman thought that the question of the self-limitation of tubercular disease would account very satisfactorily for the varying results obtained in the removal of apparatus. The only absolutely reliable guide was the existence of reflex muscular spasm, and although he had studied this symptom carefully for many years, he was compelled to admit that in a certain proportion of cases, it was very easily confounded with the mechanical resistance resulting from changes about the joint. The cases of so-called relapse he was inclined to consider as a development of new foci of the disease.

He had been interested in the author's remarks about the fallaciousness of the ether test, and the useless traumatism often inflicted upon joints by improper manipulation and examination.

Dr. Shaffer, in closing the discussion, said with reference to the sensations of the patient resulting from reflex spasm, that as long ago as 1876, a very intelligent gentleman had compared this sensation to that experienced upon attempting to dodge a blow aimed at the stomach. The intrinsic muscular element would not explain the phenomena of reflex spasm, as was shown in knee-joint disease, where the gastrocnemius muscle resists attempts at moving the knee-joint, but allows of motion at the ankle-joint. He believed that reflex spasm required for its development a peculiar specific irritation within the joint, probably of the nerves in the epiphysis. The very fact that this spasm is beyond the control of the patient's will, renders it such a reliable guide in diagnosis and in deciding when to remove the apparatus. As regards the question of excision in the case referred to, he had not presented the full history of the case, and consequently had omitted to say that the father absolutely refused to give his consent to this operation. He thought

all orthopedic surgeons recognized the self-limitation of tubercular disease, especially since the able paper published some years ago by Dr. Austin Flint. With regard to relapses, he felt that the traumatism of locomotion was sufficient in many cases to destroy the encysted condition of the tuberculous deposit about the joint, and hence, to produce a fresh infection with tubercular material of the vulnerable tissues in the capsule.

IRON CASTS AND CO-APTATION SPLINTS.

Dr. WHITMAN spoke of the advantage of employing iron splints in cases, particularly about the feet, where perfect apposition is desirable. A rough cast of the part is taken in plaster-of-Paris, and sent to the iron founder, who produces an iron cast at an average cost of one dollar. On this cast very light metal splints can be readily and accurately molded.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, May 29, 1891.

THE President, JOHN B. ROBERTS, M. D., in the Chair.

Dr. FRANK WOODBURY submitted a paper on

NITROGEN-CONTAINING FOODS AND THEIR RELATIONS TO MORBID STATES.

In connection with the paper of the evening, by Prof. Chittenden, upon the Food-value of Beef-preparations, I have been invited by the Honorable Board of Directors to contribute a few remarks upon Nitrogen-containing Foods and their Relations to Certain Morbid States. Under the circumstances, it is proper that what I have to say shall be made as brief as possible.

At the outset, our attention is drawn to some fundamental physiological facts which must be kept in mind during the discussion of this subject. The human body is now regarded as a unit composed of an aggregation or community of cells. These anatomical elements differ from each other in some respects, but agree in this: each cell consists of two parts, one living and one non-living, corresponding with cell-nucleus and formed material. What is visible to us is the non-living part, or the formed material; the real living part of the organism is hidden from view. Just as in vegetable tissue, the parts that are permanent and solid are com-

posed of the cell-walls, which may remain long after the essential living part or protoplasm of the wood-cell has dried up and disappeared — in a similar way, in the human subject, the various organs and tissues which give it form and substance are not living; the only part exhibiting vital phenomena is the soft, shapeless, and colorless cell-nucleus, consisting of protoplasm or bioplasm. This living substance, in its chemical composition, resembles the various tissues, varying somewhat according to function, but it contains one essential ingredient which is so characteristic as to confer its name upon the whole class — this element is nitrogen. The celebrated dictum, "Without phosphorus, no thought," might be paraphrased "Without nitrogen, no life." Viewed from the physiological standpoint, the name "Azote," applied to this element by Lavoisier, appears remarkably inappropriate.

As a necessary constituent of the tissues, therefore, nitrogen, in a state of combination, is always present in the human body. Since it is found in considerable quantity and in various forms in the excretions, some two or three hundred grains being discharged daily by the kidneys alone, besides what is lost by the intestinal tract and the skin, it is evident that in order to maintain life the supply must be kept up from outside sources. There are two principal directions in which we may look for the supply of nitrogen: (1) the atmospheric air, and (2) the food.

Although the atmospheric air contains about eighty per cent. of nitrogen, we may dismiss this at once as not available, beyond a very limited extent. Experiment has shown that it is not consumed or absorbed in the act of respiration; but a certain amount of air is always swallowed with the food and passes into the stomach, where it may become absorbed by the gastro-intestinal mucous membrane. It is possible that a small quantity is introduced by this channel, especially since it has been demonstrated that a moderate amount of gaseous nitrogen is excreted or exhaled by the skin.

Nitrogen-containing food must, therefore, be regarded as practically the only source of the constant supply of nitrogen which is so essential to the maintenance of the body in a normal condition. In fact, due attention has already been given to this by Liebig, Fick, Wislicenus, Parkes, Pavy, Flint, and others; and the proper relation of the two great divisions of proximate principles of organic origin, the nitrogenized and the non-nitrogenized, have been pretty closely determined. As their results are to be found

in all the text-books, I will not refer to them in detail. I may remark, however, in passing, that, from the clinical standpoint, there appears to be a fallacy underlying all these calculations of dietaries, where food values are expressed in grains of nitrogen and carbon, inasmuch as no allowance is made for waste; the entire quantity ingested is supposed to be digested and assimilated. In practice, we know that the feces contain considerable nitrogen, which is not excretory, properly speaking, but represents the excess of consumption, part of the food having escaped digestion. In nursing infants the feces consist largely of undigested casein. Even adults are not able to entirely digest milk, and if so simple an article of food as milk is not completely assimilated, what warrant have we for assuming that the nitrogenized constituents of peas and beans, or of animal tissue, will yield their full equivalent of potential force to the organism? On the contrary, we know it to be a fact, that much food-stuff passes through the alimentary canal without having its proximate principles extracted by the digestive organs and the absorbents.

We may, however, both clinically and by physiological experiment, make due allowance for the personal equation, determine with sufficient exactness the kinds and proportion of different foods required to maintain the body in a normal condition. Proceeding on the same lines, we may discover the effects of an excess, actual or relative, of nitrogen; or, on the other hand, we may ascertain the results of deprivation, either partial or complete. We may also be able to see some therapeutic applications of the knowledge thus gained.

From the time of Hippocrates, and even earlier, it has been known that health and disease are largely influenced by food, and that the effects of an animal diet are different from those of a diet exclusively of vegetables. A distinction was even made between leguminous and other forms of vegetable food. It was not until our own day, however, that the practising physician possessed sufficient knowledge of the chemistry of food and of metabolism in health and disease to enable him to direct the diet of his patients upon scientific principles. Following the definition given by Hippocrates—"Medicine consists in addition and subtraction, the addition of the things which are deficient and the subtraction of those things which are redundant; he who practises this is the best physician, but he whose practice is farthest from it is the farthest removed from a knowledge of the art"—we can now

prescribe viands suited to a deficiency of nitrogen in the system, or substitute others if there is an excess. To the therapeutic aspect of the subject I will now very briefly ask your attention.

Taking up the latter instance first, we find that a diet poor in nitrogen is useful in the several forms of rheumatism, in gout and lithemia, and also in recurring attacks of biliousness and bilious headache. Scurvy appears to be caused by an absolute, as well as a relative, excess of nitrogen in the food, and I have seen it caused by the use of an excessive amount of fresh meat among children in an orphan asylum. In its treatment, vegetable food relatively poor in nitrogen is usually employed. Some skin diseases, possibly of lithemic character, are only to be cured by withholding nitrogenized food. It seems possible that a liberal use of meat in the diet may have some connection with the development of cancer, a disease which appears to be on the increase, as was pointed out by Dr. R. A. Cleemann, of this Society, in his Address on Hygiene, delivered before the Medical Society of the State of Pennsylvania a few years ago. Dr. W. Mattieu Williams, in a little work on the Chemistry of Cookery, pointedly directs attention to the large consumption of meat as a cause of various forms of cancer. In families where a hereditary tendency of this kind exists, it is possible that it might be overcome by vegetarianism. Some nervous affections, notably epilepsy and chorea, are greatly benefitted by abstention from meat in the food.

Owing to the writings of Roberts, Fothergill, and others, a causative connection between a diet rich in nitrogen and some forms of kidney inflammation or degeneration is now generally recognized. And in the treatment of the various forms of Bright's disease, attention to the diet is generally admitted to be of prime importance. There is a widely spread opinion that nitrogenized food is favorable to the occurrence of inflammation, and for this there seems to be a scientific foundation. Parkes has shown that a non-nitrogenized diet causes lowered blood-pressure and diminished arterial tension. Meat, therefore, is ordinarily prohibited under the antiphlogistic treatment, as it was formerly called. In acute inflammations of mucous surfaces, especially in plethoric subjects, the use of animal food is usually forbidden. This should not be applied too strictly, however, for in some cases of subacute or chronic character, a generous and nourishing diet is necessary.

On the other hand, nitrogenized food may be prescribed where there is, from any cause, a deficiency of albuminous principles in

the blood, for example in anemia or chlorosis. In phthisis, this condition is sometimes quite marked, and good results have been obtained from the "beef and hot-water" plan of treatment, and also from the use of fresh bullock's blood, or hemoglobin, which requires less digestive capacity and is more easily assimilated than muscle-tissue.

Children frequently suffer from a deficiency of nitrogen. Where an infant is reared upon condensed milk entirely, the limbs are plump, but the tissues are flabby, on account of anemia. Such children are late in getting their teeth, and have little power of resistance against disease. The addition of oat-meal, barley, or rice to the milk will often bring about marked improvement and may prevent the development of rickets. Just here I might stop to point out the fallacious character of some of the arguments based upon the comparative chemical composition of woman's milk and other foods. Leeds found in a number of specimens of woman's milk that the nitrogenous constituents varied from 4.86 to 0.85 per cent. So that one specimen of mother's milk may have six times the amount of albuminous material contained in another.[1] This shows the necessity, when the child does not thrive at the breast, of examining the milk to find out if it be deficient in nitrogenized constituents. If so, the addition of beef-meal, bovinine, or other nitrogen-containing food in an easily assimilable form is advisable.

Eczema in infants, or in sewing women, is often traceable to a deficiency of nitrogen in the food, and Dr. Rohé, of Baltimore, advises the addition of meat-broth and eggs to the diet as an essential part of the treatment. Similarly, in many syphilitic eruptions upon the skin, in broken-down subjects, good food is a necessary preliminary to any specific treatment. Neurasthenia and atonic dyspepsia, which are so often associated in the same patient, especially if he is at the same time anemic, can only be relieved by nitrogenized and fatty food, administered in a form easy of assimilation and at comparatively short intervals. On the other hand, in diabetes and in obesity the diet may be largely nitrogenous, but in this case it is because there is a desire to reduce the carbo-hydrates and not because an excess of nitrogen is particularly sought after.

To return to the children, I wish to call attention to the fact that during the period of growth and development more nitrogen is needed than after the body has assumed its full stature. Hence, school children should have a due allowance of meat, and should

1 Quoted by Starr in his "Hygiene of the Nursery," Philadelphia, 1888.

be encouraged to eat oat-meal, corn, beans, peas, and other vegetables known to contain this valuable constituent.

In the foregoing brief *résumé* of an important and interesting subject, I have not made any distinction between the nitrogenous, proximate principles of animal and vegetable origin. Chemically and physiologically they are nearly identical; but practically there are minor differences of palatability, digestibility, and relative utility, which at present our limits will not permit us to consider.

BUFFALO MEDICAL AND SURGICAL ASSOCIATION.

Reported by W. S. RENNER, M. D., Secretary.

REGULAR meeting held Tuesday, June 9, 1891, in the parlors of the Hotel Iroquois, at 8.30 P. M.

THE PRESIDENT, Dr. WM. C. PHELPS, in the chair.

Dr. WM. C. KRAUSS read a paper, entitled, The People vs. Sadie McMullen — A Medico-Legal Case.

The essayist reviewed closely the family history, revealing a terrible state of things. Alcoholism, mania, dementia, etc., are of frequent occurrence, going back as far as the great-grandfather. Of twenty-five members of the family, thirteen are mentally deranged. An important point is the relation existing between the grand-parents on the father's side — being first-cousins. The early history of Sadie McMullen was then taken up, the first appearance of epilepsy when two years old, caused by fright, their changing into epileptoid as a result of treatment, their frequent occurrence, particularly at or near her menstrual periods, were all carefully reviewed. The last visit to Akron, the two letters which she received from Buffalo, and the crime, are familiar to all. On examining the prisoner at the jail in company with Drs. Mickle and Persons, nothing could be detected showing hysteria or permanent insanity. The theory of the defense was that the crime was committed while the prisoner was in an epileptoid state, — and hence irresponsible.

DISCUSSION.

Dr. WETMORE had seen two or three cases of epilepsy in young girls, probably due to hereditary influences.

Dr. COAKLEY related the history of an epileptic between fifty and sixty years of age, who walked, while unconscious, off the rear of a moving passenger train, but was not injured.

Dr. HAYD said that the paper suggested the possibility of many of our criminals being in an epileptoid state when they committed crimes.

Dr. THORNER related the case of a gentleman who had wandered about from January 14th to May 14th, in various parts of the United States. He had no idea how he had gotten from place to place, where he had been, or how he had come into possession of various articles which he had on his person.

Dr. RING said that it seemed peculiar that such people could move about without being apprehended.

Dr. GROSVENOR thinks that we can look to alcoholism and the ancestors for the production of nerve-degeneration and defective mentality in Sadie McMullen. He enumerated many conditions which can be attributed to alcoholism in the ancestors. He thought that if chronic inebriates were cared for by the state, transmission of such tendencies might be prevented.

Dr. JONES related the history of a case of classic epilepsy ; this gentleman went about in a dazed condition for days — such people were often supposed to be drugged. He objected to the naming of the epileptiod state "double consciousness," as no person could be in two conditions of mind at one time.

Dr. STOCKTON mentioned an epileptic, twenty-five years old, with good family history ; the condition was brought on by fright when the patient was seven years old. He had had classic epilepsy ; had been confined in an asylum while insane ; has now *petit mal*. Often walks two or three blocks perfectly naturally, although not conscious of what he is doing ; at other times he stands in some fixed attitude (often ridiculous). He spoke of epilepsy in a patient of his associated with early closure of the fontanelles.

Dr. HAYD asked if this epileptoid condition were always associated with, or followed, *petit mal*, and if it ever developed independently of *petit mal*.

Dr. PHELPS thought that physicians should advise patients with *grand mal* not to put themselves in dangerous places. He had had a patient who had fallen into a soap kettle after he had advised him to discontinue his occupation as a soap-maker ; this patient was scalded to the umbilicus. Speaking of marriages of consanguinity, he related the history of a family of five children, whose parents were first-cousins; of these, one had hare-lip, one chorea, one is in the Providence Asylum, one is in the State Hospital, while the fifth is a very peculiar person. He stated that he was called in by the District Attorney to examine the case of Sadie McMullen. He found family history and physical examination same as Dr. Krauss had related ; when he examined her in jail she did not appear other than sane, and she told Dr. Phelps that she had been told by her attorney not to say anything to any per-

son without his permission; neither would she answer any questions until the doctor obtained permission for her to do so from her attorney. He found that she was subject to attacks of wandering off, but could not get the history of many. Three things were to be noted in her attempt to drown herself: the road where there was but little water; she helped herself out of the water, and did not try to get back into the water after she was taken out. He considered the case one of hysteria; he did not think she was conscious from the time she left the store until she entered the water: he did not consider her accountable for her acts; he knew nothing of her history since her confinement in the State Hospital; legally it amounted to the same thing whether she were suffering from epilepsy or hysteria.

Dr. KRAUSS said that at present she is gaining in every respect, that Drs. Andrews, Hurd, and others of the staff at the State Hospital, hold that she never had a homicidal tendency in the world. In reply to Dr. Hayd, he said the epileptoid state does not come on suddenly; you must have a previous history of epilepsy; it follows either *grand mal* or *petit mal*; he agreed with Dr. Jones that there is no such thing as "double consciousness," and had avoided the use of this name in his paper.

Meeting adjourned at 10.30 P. M.

THE MEDICAL SOCIETY OF THE COUNTY OF ERIE.

Reported by Dr. B. G. LONG, Secretary *pro tem.*

SPECIAL meeting of the Erie County Medical Society, to take action upon the death of Dr. F. H. Potter, in Association Hall, July 17, 1891.

The President, Dr. E. C. W. O'BRIEN, in the chair.

Dr. B. G. LONG was appointed Secretary *pro tempore*.

The PRESIDENT, in stating the object of the meeting, paid tribute to the worth of the deceased, as follows:

Gentlemen—It is a sad event that brings us together tonight, meeting, as we do, to take suitable action in regard to the death of our greatly esteemed fellow-member, Dr. Frank H. Potter. Death has entered our association with grievous frequency during the past twelve months, and I am sure we feel that, in the present instance, the grim destroyer has taken one of our most highly respected and valuable members. Our deceased brother, as we well know, had accomplished a great deal that was highly creditable during his medical career. Of unusual natural abilities, which were well trained and carefully directed by his experienced and skilful father, he had won distinction

to a gratifying degree in the important specialty to which he devoted his earnest attention for some years past. We knew him as a constant student, and as an untiring worker in his professional field. The well-marked recognition of his unusual talents by the local leaders of our profession must have been a source of warrantable pride and pleasure to his many friends, a fact which will, in a measure, afford consolation to those who will grieve that his earnest and useful life, that seemed so full of bright promise, has ended. His relations with his professional brethren were of the pleasantest nature, and the character of his private life was a good example for all men.

Upon Dr. Vandenbergh's motion, a committee of three upon memorial was appointed by the chair, as follows: Dr. F. W. Bartlett, Dr. F. W. Abbott, and Dr. DeLancey Rochester.

A telegram of sympathy from Dr. F. W. Hinkel was read by the Secretary.

Dr. J. PARMENTER: It was my very great privilege to have known Dr. Potter intimately for some years. There is no need for me to say anything of his professional attainments; they are known to us all. But it is of his great moral worth that I like most to think and speak of him. No man of my acquaintance ever showed more loyalty to his friends, more gratitude for any little attention, more tolerance for the opinions of others, no matter how radically they differed from his own, than Dr. Potter. He took a deep, earnest view of life, was untiring in his efforts to promote good citizenship (as evidenced by his work as a civil service reformer), and assisted, as far as lay in his power, every worthy philanthropic and educational measure that was brought to his notice. He ever urged for higher education, not only in his chosen profession, but in every department of learning. He was a teacher of more than ordinary ability, as he amply demonstrated during the years he taught in the Niagara University. It was a great pleasure to me when he was elected to the chair of laryngology in the University of Buffalo, for we all felt that a distinct addition had been made to the teaching force of the college. His death is a loss that only his more intimate friends can justly estimate, for he never paraded his virtues or sang his own praise. His work did all this for him. Many of us have lost not only a colleague in whom we took pride for his energy and achievements, but a dear, loyal friend, whose life and example stood for all that is ennobling and good.

Dr. EDWARD CLARK: I feel that I would be derelict in my duty if I should let this opportunity pass without paying my tribute of respect to the memory of my friend, Dr. Frank H. Potter. During the past ten years, my relations with Dr. Potter were so intimate, that I had ample opportunity to learn to know him well. When he first entered upon the practice of his profession here in Buffalo, we became associated together

as assistant surgeons at the Buffalo Hospital of the Sisters of Charity. At that time a friendship sprang up between us, which continued unbroken to the time of his death. For the past three years we have lived side by side as neighbors, and my daily association with him afforded me unusual facilities for knowing and appreciating his sterling worth. He was modest and unassuming to a great degree, so far as his professional attainments were concerned. I regarded him as a good student and a careful observer. He was rapidly becoming an authority and an expert in his special field, and his careful and conscientious efforts in this line gave great promise of a brilliant future. To my mind the saying that "Death loves a shining mark," was never more forcibly illustrated than in the untimely death of Dr. Potter. He was a dutiful son, a fond husband and father, and while our profession will feel keenly his loss, his death falls as a crushing bereavement on those who were bound to him by nearer and dearer ties.

Dr. J.W. Putnam: Dr. Potter and myself were classmates at the medical college, and have been intimate friends ever since. In the course of a friendship of twelve years I have always found him a friend on whom one could lean for advice. He was a man who always gave his friends the benefit of his best judgment, never jumping at conclusions. Fair in his way of looking at questions, and fair in his dealings with men, he demanded equal fairness toward himself.

Dr. Potter was fearless in his denunciation of what was wrong, and was firm in maintaining his opinions, no matter who differed from him. He was an earnest seeker after the truth, not only of medical, but of abstract questions. His habits were those of a methodical, painstaking student. He profited by his experience, for his case records were carefully kept and studied. He had the confidence of his friends, both lay and professional, and he never abused it. He had already attained prominence in his specialty, and had he been spared he would, without doubt, have become eminent.

But Doctor Potter was not satisfied with simply doing his medical duty. He felt that the city where he lived had claims upon him, and he devoted himself to the work of Civil Service Reform. Of delicate physique, he never shrank from his work, and often after a tiresome professional day he would attend to the duty of examining candidates for the civil service appointments. Handicapped as he was by a weak physical nature, he, nevertheless, accomplished more than men who were far more favored by nature.

Personally, as a friend and companion, I have many fond recollections of him as the appreciative listener, the ready conversationalist, always willing to do a good service if it lay in his way.

Only those who knew him intimately can appreciate how much the profession has lost by losing Frank Potter.

Dr. H. D. Ingraham : Mr. President, I did not intend to say anything tonight, as I have already expressed what I had to say in regard to our late friend upon a similar occasion to this. Yet a remark made at another meeting, by a former student of Niagara University, led me to believe that Dr. Potter has left a deeper and more lasting impression upon many of the younger members of the profession than ever I supposed. This young man said that he had "listened to Dr. Potter's lectures for three years, first upon materia medica, and later upon his special branch ; that he always presented his subject clearly and concisely, often criticising methods, but never criticising individuals or speaking lightly of other members of the profession. Although he was highly respected as a teacher, it was his conduct as a gentleman that made the strongest impression upon the student." Mr. President, I believe this is true, and although Dr. Potter was a young man, he had all the finer and nobler qualities of the physician of the older school. It is a sad fact that there are too few gentlemen in the medical profession at the present time. If there were more physicians like Dr. Potter there would be less rushing into print to air supposed grievances. It must be a great satisfaction to his friends to know that although he was highly esteemed as a physician of ability, yet his strongest characteristics were his noble, gentlemanly qualities; and although his life was short, yet his students will look back upon his career as an example worthy of their best efforts to emulate.

Dr. Lucien Howe : I would add just one word to this tribute of respect to the memory of Dr. Potter. It is not because I knew him long, or well, or, indeed, always pleasantly, but it is rather because on one or two occasions his interests and mine seemed to differ in a small way, and because I think that it is possible to gain a better view of a man's character when standing in front of him, perhaps opposed to him, than that which others have who have always stood beside him. On an occasion like this it would be ungenerous in the extreme not to join my feeble voice in the universal expression of regret at his loss, for I, too, can bear witness, as perhaps every one can, to his sturdy qualities as a manly man, — generous, large-hearted, strong, and positive. Honest in his convictions, and loyal to those who were his friends, he won the admiration and esteem even of those whose opinions and interests differed at times from his own.

Dr. Potter's death creates still another vacancy in that class of bright and active younger men who began from the very first to make for themselves a place in the community and in the profession. The amount that he has accomplished by earnest work, and the example that he set to other physicians as the type of a good citizen, is a record of which many a man, much older in years, might well be proud. His early loss well illustrates the fact that

We live in deeds, not years; in thoughts, not breaths
In feelings, not in figures on a dial
We should count time by heart-throbs: he most lives
Who thinks the most, feels the noblest, acts the best;
And he whose heart beats the quickest lives the longest—
Lives in one hour, more than in years do some
Whose fat blood sleeps, as it slips along their veins.

Dr. HUBBELL: Ever since the organization of the Medical Department of Niagara University, in 1883, Dr. Potter has been connected with that institution, in some capacity, as teacher. At first he was assistant to the chair of surgery. Afterwards he was made Assistant in Materia Medica, and lectured for three years in that department in the regular courses. In 1886, he decided to relinquish general practice and limit his work to diseases of the nose, throat and respiratory organs. This being the case, I recommended that he be appointed to lecture on laryngology in the school. This was done, and he served in that capacity till a few weeks ago, when, in furtherance of his own interests, as he (Dr. Potter) believed, he severed his connection with Niagara, much to the regret of the faculty, to take a position in the Buffalo Medical College. In leaving the school of his first adoption, he carried with him the friendship and good wishes of every member of its faculty. As a speaker and teacher, few excelled him in systematic and clear presentation of thought. He was honorable in every respect, and he was a perfect gentleman socially. As a companion he was most genial and entertaining; as an associate he was considerate and helpful: and as a practitioner he was ambitious and progressive. He was greatly respected as a teacher. He was tenacious of his convictions, yet he made few enemies. With a high ambition to excel, with a clear and discriminating mind to guide him, and a facile pen to aid him, future years, had his life been spared, would, without doubt, have placed him among the foremost in this country in his chosen field of labor. I held the deceased in high esteem, and greatly deplored the premature cutting off of such a life. I would be glad to say more, but this is sufficient to indicate my estimate of Dr. Potter and my feelings toward him.

Dr. JOHN H. PRYOR: I have known Dr. Frank H. Potter from the bright beginning to the lamented ending of his short medical career. Our companionship was sufficiently intimate to enable me to form an opinion of his ability and rare traits of character, and I learned to admire him as a physician and prize him as a friend. He possessed natural talents of an unusual order, and a determination to excel in a profession which he honored and reverenced. Always progressive, patient, and studious, he belonged to a small band of scientific workers who appreciated his worth and knew that modest merit would place him in the front ranks in his specialty. He was a careful observer, cautious in forming an opinion, and displayed exceptionally good judg-

ment. As a writer he was particularly successful, and his articles commanded attention by their clinical value and literary excellence. The fact that some of his contributions received flattering notice far from home, was a great source of satisfaction to him and his friends. He toiled because he loved work and had learned the secret of methodical investigation. A constitution inclined to be delicate limited the scope of his activity, but could not subdue his will, and the struggle, at times, against the harassing, fettering influence of ill-health only revealed latent qualities of resistance to trying obstacles. Although ambitious, he was true to his ideals, and the aim was so high that only slow years of conscientious effort could lead to a consummation. Of late, the way to his aspiration seemed most encouraging, and the prospect was brightening with new and cheering expectations. In the fair retrospect of his life, lofty elements of character shine in radiant prominence. Frank Potter was more than a physician ; he was a man. The beauty and purity of his moral nature was exhibited in the duties and trials of his vocation, and he represented the most elevated ideas and noblest impulses which give lustre and high meaning to a calling. Any hope for appreciation and reputation rested upon modest and unassuming merits, and confidence in the approbation gained by results. No man knew better the unwritten laws of good taste and delicate consideration. Natural elegance of manner, winning frankness, and warm sympathies, made him a most attractive and charming companion, and distinguished him as a refined gentleman in every circle. Affections were very strong with him, and tests of sincerity proved unswerving loyalty. To know him socially was a joyous experience. The product of his mind was pure and lofty, and often brilliantly enriched by literary gems from old quaint regions which he had found time to visit. He could be stern and tender. His opinions were strong, and if necessary he was fearless in advancing them. Intensely sympathetic, unselfish, finely made and keenly sensitive, he was quickly responsive in the mysterious language of feelings, and his friendship was marked by those lingering overtures of sentiments which the daily conflicts never stifled. In him were combined the essential qualities which would have more respect and commendation under any circumstances. By his death the profession suffers a double loss ; all that he had accomplished seemed but preparatory. He was regarded as a man with a future, and his early removal leaves the promises unfulfilled. The memory of Frank Potter will stir sad recollections, but they can only be expressed in words of heartfelt praise. To his friends he left all that he could — the example of a useful and beautiful life.

The committee on memorial here reported as follows :

Whereas, Death has removed from our ranks our esteemed fellow-member, Dr. Frank Hamilton Potter, in the morning of a professional career that gave promise of a brilliant noon :

Resolved, That in his death the Erie County Medical Society has lost one of its most studious, industrious and progressive members, one who in his chosen specialty had already attained an enviable position from his useful contributions to medical literature and science, and which had won for him distinguished recognition from the scientific bodies with which he had been connected.

Resolved, That we highly appreciate his efforts in behalf of elevating the standard of medical education.

Resolved, That as citizens we pay especial tribute to his valuable services in improving the municipal civil service.

Resolved, That in the purity, modesty, and uprightness of his character he was an example worthy of emulation.

Resolved., That we tender our deepest sympathy to his bereaved family and relatives ; and that we attend his funeral in a body.

Dr. DeLancey Rochester: Mr. President, I move the adoption of the resolutions as read, and at the same time I desire to present a slight personal tribute to the worth of Dr. Potter. It has been my good fortune to have known Dr. Potter long and intimately. Our friendship began when we were but fifteen years old, and has lasted, unbroken, since. I have seen him in many trying positions and never have known him to do the wrong thing. His character was well rounded ; there was nothing small or narrow about him. He never jumped at a conclusion, but always considered every question that came before him from every side ; but having found an opinion, he had the courage of his convictions and combatted for them, through thick and thin, until he won.

In his professional work, he made many original observations, added to our knowledge of diseased conditions, and invented several instruments of great value in his special field of work. He has devoted more time than any other medical man in the city to the improvement of the municipal civil service, and to his untiring efforts in this direction is due, in large part, the successful application of the civil service reform ideas to the city government. But, among his friends and in his family, his virtues shone out preëminently, and made us love him for the purity, modesty, and unselfishness of his life. Truly, his was a beautiful character.

Dr. F. W. Abbott : Mr. President, I wish to say a very few words in memory of my friend Dr. Potter. My acquaintance with him began about ten years ago, when he was resident physician at the Rochester City Hospital. I had occasion to visit that institution, and easily recall the figure of the grave, courteous, dignified young gentleman who rose from his book to greet me as I entered. When he came to Buffalo we were not thrown together much, and I did not get well acquainted with him until he was appointed Surgeon to the Erie County Eye, Ear and

Throat Infirmary a few months ago. There I met him frequently, and learned to esteem him highly for his personal character and professional ability. At the meetings of the staff, while courteous and deferential to his seniors, he was ready with well-considered plans and ideas of his own for the management of the institution. I looked forward with pleasure to years of intimate association in this work with so pleasant and accomplished a gentleman, but he has been taken from us, and we deeply mourn his loss.

Drs. Irving M. Snow and John Cronyn also spoke very feelingly to the memory of Dr. Potter.

A motion to adopt and transmit copies to the papers and family by Dr. Rochester, was seconded by Dr. Putnam. Carried.

ACTION OF THE FACULTY OF NIAGARA UNIVERSITY.

SPECIAL meeting of the faculty of the Medical Department of Niagara University, held in the faculty rooms, July 17, 1891.

The President, Dr. CRONYN, stated the object of the meeting to be to take action on the death of our late associate, Dr. Frank Hamilton Potter. In fitting terms the noble qualities of Dr. Potter were enumerated—his many virtues, universal friendship and gentlemanly bearing made him honored and beloved by all.

Dr. LOTHROP paid a high tribute to his memory, and moved that a committee be appointed to draw up a fitting memorial.

Drs. Lothrop, Hubbell and Krauss were appointed by the President to serve on the committee.

In the meantime the following members of the faculty availed themselves of the opportunity to speak personally of their acquaintance with Dr. Potter, as follows:

Dr. H. D. INGRAHAM.—*Mr. President:* You have just remarked that while the committee are out it is proper for those who remain to say anything that we wish in regard to our late friend, which you think will be in his praise, as you believe nothing but good can be said of him. I fully agree with you, Mr. President. I cannot say anything here or elsewhere of Dr. Frank H. Potter except what is good. I know nothing about him but what is good. I have been quite well acquainted with him for the past eight years. I have met him in our deliberations as a faculty, as a teacher, at the hospital, and in various other professional and social relations, and have always found him an able physician and an honest, honorable man. Since he went into special practice he achieved an enviable position in a very short time, one that many older men might be proud of. As an honest, honorable physician and a man he was certainly the equal of any and the superior of most of the profession, always treating his professional brother as he wished to be treated.

Dr. J. A. MILLER.—*Mr. President:* Words are meaningless in giving expression to my feelings on this occasion. Ever since my return to Buffalo Dr. Potter has been one of my warmest friends, and I can say that I found him a *true friend*, indeed. He was a man whose purity of soul, honesty and sincerity of purpose, nobility and manliness of character, endeared him to all who knew him.

Dr. PERSONS: I heartily concur in all that has been said concerning the private and professional life of our late friend and colleague, Dr. Potter. My acquaintance with him began soon after I came to Buffalo, eight years ago, and my admiration for his many noble qualities and excellent attainments increased each year as we became more intimate. The whole expression of his life was one of purity and of noble purposes; the mainspring of his ambition centered in a desire to benefit and elevate his fellow-man.

In the many confidential talks we had regarding our college work, his greatest aspirations seemed to be in the interests of a higher medical education, and the hope that the medical profession would soon appreciate the efforts of his colleagues in its behalf. His loyalty to his friends, and to the institution with which he had been so long connected, cannot be questioned, and his most recent utterances served the more strongly to assure us of his good wishes.

I can only deplore the fate that has taken from our midst a man whom we all loved and honored, whose natural gifts and training would have eventually placed him in the front rank of his chosen profession. His estimate of character was generally very near the truth, and his charity for others' weakness afforded an example which all could emulate with profit.

In the untimely death of Frank Hamilton Potter the profession has lost one of its best exponents of "the gentleman in medicine."

Dr. HUBBELL: Dr. Potter, having been connected with this school from the early part of its organization till, much to our regret, he tendered his resignation a few weeks ago, it is most fitting that we should, as a body, pay our respects to his memory. The presence, today, of nearly every member of our faculty who is not absent from the city, attests, if in no other manner, the esteem and regard in which he was held by us.

The memorial which the committee, through its chairman, Dr. Lothrop, has presented, truthfully, and I believe unanimously, voices the sentiments of this faculty. What I would desire to say would largely be but a repetition of them. I wish to add, however, my personal tribute to his character and memory. The social, and especially the college, relations between Dr. Potter and myself have been more or less intimate for several years. When I learned that he intended to relinquish general practice, in 1886, and pursue special work in diseases of the nose and throat, I invited him, upon the sanction of the faculty, to teach the senior students in this department, which the trustees of the university had assigned to me. He had already proved himself an apt and clear teacher, and in this new and preferred field he still further distinguished himself in the estimation of those who were the recipients of his instruction. Another proof of his success as a

teacher was the uniformly high percentage which students, each year, acquired in his examinations.

In his relations with this faculty Dr. Potter was always upright and courteous. His knowledge of men, his clear insight, his acute sense of discrimination, coupled with honor, culture, and excellent professional attainments, made his presence desirable and his opinions of weight in the deliberations of this faculty. He possessed the qualities of character and loftiness of purpose which, I believe, would have made for him a wide reputation in his specialty, could life and health have been spared. Dr. Potter's death is a serious loss to the community, to the profession, to a doting household, and a personal loss to me.

Dr. Geo. Fell: I have been acquainted with Dr. Potter for some years previous to his association with the faculty of this college. My relations with him have been such that I had the fullest respect for his manly, upright character. There was something inexpressibly sad in the blotting out of a life just beginning to bud freely into the successes and joys which follow the trials always experienced, particularly in the medical profession, before honest success is attained. Professionally successful, the future offered hopes most encouraging. A young, happy family growing up. What more could be asked? And yet this life is striken down just when it appeared to be most needed to fill out the meed of hopeful, expectant satisfaction to a large circle of relatives and friends. The problems surrounding our lives are, indeed, from a rationalistic standpoint, unexplainable. I respected Dr. Potter, and I sympathize with those who mourn his loss, and came here to express my feelings.

Dr. H. C. Buswell: I was privileged to listen to Dr. Potter's lectures for three years, and can, therefore, speak intelligently of him as a lecturer. He never addressed a class without preparation, and, being thoroughly conversant with the subject, spoke readily, and presented the subject-matter concisely and logically, making it easy for the student to comprehend and remember. As a lecturer and teacher he had few superiors in the college.

But that for which I honored him most was the fact that he was an educated, professional *gentleman*. Deplorable as it may be, there undoubtedly exists a class of medical men, who, under the false color of progression, are nothing more nor less than medical hucksters, whose self-laudation and solicitation for trade are only limited by their vocal capacity and the versatility of their bosom friends, the reporters of the penny papers

In direct contrast to these methods we have seen our lamented friend, in a legitimate and honorable manner, acquire substantial practice and high reputation. His private and professional conduct were above reproach. Had we more like him, codes of ethics and votes of censure would be less needful.

I hold sacred the memory of Frank Hamilton Potter because of his ability, integrity, and honor.

Dr. William C. Krauss.—I do not wish to let this occasion pass without paying my tribute to the memory of our late colleague and asso-

ciate, Dr. Frank Potter. It is now about two years since I first met him, and since then we have been thrown together socially and professionally, so that I had learned to esteem and honor him highly as a friend and a gentleman. It was a pleasure to be in his company; and in the many faculty, journal, and society meetings which we have attended together, I have more and more been impressed with his qualities as a just and conscientious leader. Among the younger men of our profession he was sought for his opinions, and we always found him squarely on one side, and that side proved to be the right side.

I regretted very much when I heard of his intent to leave us, because men of his intelligence and judgment go far towards making a thorough and illustrious faculty. His name and fame had extended beyond the city limits, and I doubt not but that in a few years he would have been regarded as a high authority in his chosen specialty. His death we all mourn, more so, perhaps, because it came without warning; his memory will ever be dear to us.

Dr. S. A. DUNHAM: I believe it the sentiment of every student of this university that Dr. Frank Hamilton Potter was highly esteemed and respected as a teacher, and his personal friendship was inestimable. Socially and professionally his acquaintance was very gratifying and helpful to me. His early success and popularity was certainly due to his integrity of character and earnestness of purpose.

The committee on memorial reported as follows:

The Faculty in Medicine of Niagara University, assembled, at the call of its President, to give expression to its sentiments on the death of our late associate, Frank Hamilton Potter, M. D., late Lecturer on Laryngology in this College, desire to record their sorrow at the Divine dispensation which takes from earth a public-spirited citizen, from the medical profession an accomplished member, and from his family circle a devoted son and brother, and a loving husband and father.

We record with pride his success and influence as a teacher in this School. The uniform testimony of the senior students, to whom he lectured, is expressed by his popularity among them, and in the thorough comprehension of the subject he taught among his auditors.

In the specialty to which he consecrated his energy and skill, the success of his labors is attested by the concurrent testimony of the profession and his patients. The assiduous study and work, and eminent ability which he brought to his profession, were soon to be recognized and rewarded by an honor, which he cherished and merited, in the election to membership in the National Association of Laryngologists.

Beyond his profession, he had already laid up a fund of intellectual knowledge which gave him recognition in the social and learned circles of this city.

In his daily walk and conversation he was singularly pure, and

honorable and, upright, respected by all, and devotedly loved by his intimate friends.

Such a life, suddenly brought to a close at an early age, when he was soon to enter upon a career of professional success for which he had long and diligently struggled, is another example where death selects a shining mark, interrupting the execution of matured plans and blighting honorable aspirations, which would have led to a distinguished position in his chosen specialty.

This Faculty beg to convey to the afflicted family assurances of our deepest sympathy in their bereavement.

It is also directed that the members of this Faculty attend the funeral services of our late associate in a body.

It is further directed that this memorial be engrossed, and the Secretary transmit the same to the family of the deceased.

Respectfully submitted,

THOS. LOTHROP,
A. A. HUBBELL,
WM. C. KRAUSS,
Committee.

MEDICAL DEPARTMENT, NIAGARA UNIVERSITY, July 17, 1891.

ACTION OF THE FACULTY OF BUFFALO UNIVERSITY.

Reported by DR. IRVING M. SNOW, Secretary.

A SPECIAL meeting of the faculty of the University of Buffalo, Medical Department, was held Friday evening, July 17th, Dr. LUCIEN HOWE presiding, and Dr. IRVING M. SNOW acting as Secretary.

Dr. HOWE announced the death of Dr. Frank H. Potter, Clinical Professor of Laryngology, and said that it was fitting that the faculty take some action upon the loss of so talented a colleague.

A committee of three was appointed to draft resolutions, consisting of Drs. Putnam, Parmenter and Rochester.

Dr. BARRETT eulogized Dr. Potter's abilities, and deplored his premature and untimely death.

Dr. A. L. BENEDICT spoke of the fatality which had followed the house surgeons of the Rochester City Hospital, four of whom had died of the same disease from which Dr. Potter died.

REPORT OF COMMITTEE.

WHEREAS, The University of Buffalo has sustained a serious loss in the untimely death of Prof. Frank H. Potter;

Resolved, That we put on record our appreciation of his high professional attainments, of his ability as a teacher, of his devotion to the cause of higher medical education, and of his high ideal of the duties of citizenship, and of the purity of his character.

J. W. PUTNAM,
JOHN PARMENTER,
DELANCEY ROCHESTER,
Committee.

The report of the committee was adopted.

Dr. PARMENTER thought Dr. Potter's pure and energetic character would have a lasting influence upon his friends.

Dr. PUTNAM spoke of his frail physique, and of the great amount of work which he accomplished, both professionally and for the cause of civil service reform.

Dr. HOWE alluded to Dr. Potter's strong character, and considered his premature death a serious loss to the younger element in the college. He spoke especially of the sympathy we all felt for his father, Dr. W. W. Potter.

Dr. ROCHESTER moved that the chair appoint three members to represent the faculty at the funeral.

Adjourned.

MEMORIAL OF THE THURSDAY CLUB.

The Thursday Club, of Buffalo, at a special meeting held at the Buffalo Club, July 23, 1891, Dr. James W. Putnam being in the chair, and Dr. John Parmenter acting as Secretary, adopted the following memorial in affectionate remembrance of their lamented colleague, Frank Hamilton Potter, M. D.:

By the death of Dr. Potter the Thursday Club loses one of its founders, who, from the day of its organization to its recent adjournment for the summer vacation, was one of its most loyal and devoted members.

A man of serious purpose and strong convictions, his modest bearing, courtesy to antagonists in the heat of debate, and generous respect for the opinions of others, endeared him to his colleagues, and will preserve his name and example among the most honorable traditions of the club.

Dr. Potter was not only a charter member, but a model member, of the Thursday Club. He was a manysided man. The windows of his mind and heart were open all around, and light from every quarter was welcome. He sought the truth, and was not afraid in following it to depart from beaten paths and to stand up and be counted with the temporarily unpopular.

As a simple testimonial of their love and esteem for their late comrade, the members of the Thursday Club direct this expression of their sentiments to be sent to Dr. Potter's family, and to be made a part of the club's permanent records.

Selection.

ARISTOL.

Dr. Alois Pollak (*Therapeut. Monatsh.*, *VII.*, *1893*,) recommends aristol as an antiseptic, and as a remedy in various skin diseases, on the ground of experiments made in numerous cases. Inasmuch as this substance is insoluble in water, he employed it chiefly as a dusting powder, or in ethereal solutions or ointments. For obvious reasons, it cannot be utilized for disinfections of the hands, instruments, and the site of operation, or as an antiseptic during the operative procedure. On the other hand, it is very serviceable for the treatment of wounds after operations, or of neglected injuries. It has the great advantage of being effective in small quantities, so that wounds need only be covered with a thin layer; if desired, it may be diluted with sugar of milk. In all the cases treated with aristol by the author, the healing process took place without reaction. Fever never occurred, and if present before operation, it disappeared regularly within the first few days after its performance. There was an entire absence of pains, granulations were developed with remarkable rapidity, and formation of epithelium took place promptly. The period of healing was remarkably short.

The cases treated with aristol comprise the following:

1. Anal fistula; incision and curetting; tamponning with aristol gauze after previous application of the powder; cure in twenty days. 2. Abscess in the gluteal regions, of the size of a fist; incision and insufflation of aristol; healing accomplished in seven days. 3. Lymphadenitis of the neck (tuberculous?); incision, extirpation, curetting; application of aristol in powder and tampons. Eight days later, fresh tubercle nodules in the granulations and cicatrix: after a second enucleation and the use of aristol, healing took place. 4. Periostitis of the mastoid process, incision, curetting followed by application of aristol powder; cure on the eleventh day. 5. Injury of the thigh by a rusty nail; wound has a discolored suspicious appearance, is covered by gray necrotic granulations, curetting and application of five per cent. aristol ointment; cured in fourteen days. 6. Necrotic ulcer in consequence of a contusion; incision of the undermined margins; application of aristol powder; healing ten days later.

In addition to these cases which are reported in full, the author

mentions four minor operations for tumors, three extractions of foreign bodies, a wound inflicted by a pen dipped in ink, a lacerated wound of the scalp with exposure of the bone, three cases of purulent adenitis, three phlegmons, and several cases of buboes, all of which were successfully treated with aristol.

As regards the employment of aristol in the treatment of cutaneous diseases, he cites the following cases:

Eczema scrofulosum.— Among the ten cases, no curative effect was produced in six; in the remaining four it was slight. Hence, aristol is not to be recommended in this disease.

Eczema marginatum.— In this affection an excellent result was obtained from the use of a ten per cent. ointment with vaseline.

Varicose ulcer.— A five per cent ointment of aristol and vaseline was employed with advantage.

Pernio.— In the majority of cases, a ten per cent. solution of aristol in collodium and, later, aristol plaster, proved very effective.

Owing to its convenient manner of application, aristol seems especially applicable for the physician's use in his office practice.— *Deutsche Med. Zeitung*, April 2, 1891.

Progress in Medical Science.

MEDICINE.

BY

WM. C. KRAUSS, M. D.

In an able article on Crime and Responsibility, by Daniel Clark, M. D., in the April number of the *American Journal of Insanity*, the following deductions are obtained:

1. The natural history of crime shows that brains of chronic criminals deviate from the normal type and approach those of the lower creation.

2. That many such are as impotent to restrain themselves from crime as the insane.

3. That crime is an ethical subject of study outside of its penal relations. That insanity and responsibility may exist. That some insane can make competent wills, because rational. Those classes of humanity exempt from responsibility are: first, the child of immature age; second, the idiot; third, the imbecile; fourth, various classes of the insane; fifth, the epileptic, when fits are coming on or leaving; sixth, the dipsomaniacal in the frenzy of drunkenness.

Hesselievitch — *Ibid* — studied the influence of stomach lavage upon the assimilation of fats in five healthy individuals. Each experiment lasted eighteen days, and was divided into three periods of six days each. The lavage occurred half an hour before dinner, the water being 28° to 30° centigrade. In four cases the author noted an increase in the assimilation of fatty matter, and in one case a decreased assimilation. This effect continued for some time after the lavage.

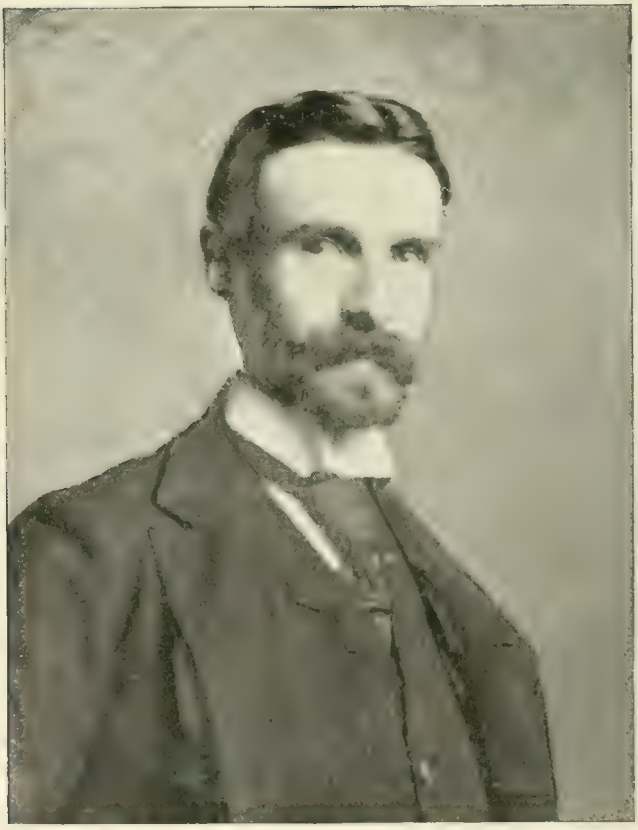
In *The American Meteorological Journal* for May, 1891, is an interesting article by Hildebrandsson, on "Is the Influenza Spread by the Wind?" He takes up the course of the epidemic, beginning in St. Petersburg on the 15–17 of November, 1890, then follows it to Hamburg, where it first appeared December 1st, and Paris December 15th. All reports from the newspapers agreed that the influenza spread from east to west, in which case the infection had gone *against* the wind, since at this time there was not a single easterly wind over the countries about the Baltic sea. It appeared in Stockholm on the 27th of November, and was, therefore, impossible that the infection could have been imported from Russia by the wind.

The result of this research is, of course, that *the influenza is propagated by infection, and conducted from place to place through human circulation, and that the time of incubation is two-to three days.*

The state of the weather seemed to have had no influence on this sickness. In fact, the influenza raged with the same severity in countries possessing very different climates, and during very different weather conditions.

It seemed unnecessary for a person to be in direct contact with a sick person for infection. On the contrary, it is almost certain that the infecting germs can be transported with corpses, clothes, etc. A curious fact has been related to me by Professor J. Hann, of Vienna. At Christmas, when Vienna was scourged by the influenza, two gentlemen went up to the meteorological observatory at the top of the Sonnblick (10,000 feet). The single observer living at this height, isolated from the world, fell sick of influenza a few days after their visit. Of course the visiting gentlemen were in the best of health, since they could ascend a mountain of 10,000 feet in winter.

(*From the Illustrated Buffalo Express, July 26, 1891.*)



DR. FRANK HAMILTON POTTER.

(*Died July 16, 1891.*)

BUFFALO MEDICAL AND SURGICAL JOURNAL

A MONTHLY REVIEW OF MEDICINE AND SURGERY.

EDITORS:

THOMAS LOTHROP, M. D. - - WM. WARREN POTTER, M. D

All communications, whether of a literary or business character, should be addressed to the editors: 284 FRANKLIN STREET, BUFFALO, N. Y.

VOL. XXXI. AUGUST, 1891. No. 1.

FRANK HAMILTON POTTER, M. D.

IT IS our painful duty to announce to the profession that death has again invaded the editorial corps of the JOURNAL, and taken from the activities of life Dr. Frank Hamilton Potter, for several years an associate editor and co-worker with us. Following within so brief a period the deaths of the lamented Davidson and Campbell, with whom our readers are familiarly acquainted through their contributions to our pages, the sudden taking off of another editorial *confrère*, a brother—beloved for noble qualities of head and heart, and a son who inspired parental pride for his purity of life and conduct, and his honorable ambition in scientific and literary work—is a mysterious dispensation which eternity can alone explain.

The subject of this notice was the only son and eldest child of Dr. William Warren Potter, the managing editor of this journal, and was born in Cowlesville, Wyoming county, N. Y., January 8, 1860. Descended from a long line of American physicians, whose reputation in the State and country has been a source of honorable pride in his family, he early directed his attention to medicine as the profession of his life, and his intellectual training was guided with this end in view. He was graduated at the Buffalo Medical College in the class of 1882, at the early age of twenty-two years. Prior to his graduation, he served in the Rochester City Hospital for two years. After receiving his degree he located in this city, and, on the organization of the Medical Department of Niagara University in 1883, was appointed Clinical Assistant in Surgery. He subsequently held the lectureship of Descriptive Anatomy in 1884, Demonstrator in Surgery, and Lecturer on Botany in

1884–85, Lecturer on Materia Medica from 1885 to 1888, and Lecturer on Laryngology from 1888 to May, 1891. In recognition of his active efforts and conspicuous ability, the Niagara University conferred upon him, in 1885, the *ad eundum* degree of Doctor in Medicine. At the close of the session of 1891, he severed his connection with the school with which from its organization he had labored successfully, and accepted the position of Clinical Professor of Laryngology in the Buffalo University Medical College.

At one time he was a member of the surgical staff of the Sisters of Charity and Emergency Hospitals; also of the Buffalo Medical and Surgical Association; the Erie County Medical Society; the Buffalo Pathological and Obstetrical Societies; the Medical Society of the State of New York, and of the American Medical Association, having been Secretary of the Laryngological Section in 1890. He was recently chosen by the Council of the American Laryngological Association to membership in that body — a flattering recognition of his ability and reputation in the special department of medicine which he had selected for his life-work. He was also a member of the Saturn and Thursday Clubs of this city, in which his social qualities and literary attainments were recognized, and his broad and liberal culture highly esteemed by the educated men with whom he delighted to associate.

He was a frequent contributor to the medical and literary societies of which he was a member, the products of his pen commanding attention, both at home and abroad, for their research and clearness of expression as well as beauty of style and diction. The following may be mentioned as some of the titles of his professional contributions:

Treatment of Acute Tonsilitis in Children. B. M. & S. J., Vol. XXVII., p. 455.

Tuberculosis of the Nose, Mouth, and Larynx. B. M. & S. J., Vol. XXVII., p. 295.

Congenital Bony Occlusion of the Nares.— Report of a Case. B. M. & S. J., Vol. XXVIII., p. 74.

Treatment of Acute Coryza. B. M. & S. J., Vol. XXVIII., p. 302.

The Influence of Oral Irritation in the Production of Disease of the Upper Air-Tract. B. M. & S. J., Vol. XXIX., p. 12.

The Use of Menthol in Diseases of the Upper Air-Passages. Journal A. M. A., February 1, 1890.

On the Treatment of Hay-Fever. B. M. & S. J., Vol. XXX., p. 88.

Neurasthenia and Nasal Disease. Loc. Cit. p. 337.

Croupous Rhinitis. (Two papers.) Trans. Med. Soc. S. N. Y., 1889 and 1891.

Cystoma of the Nasal Passages: with Report of a Case. Candidate's Thesis for Membership in American Laryngological Association. (Unpublished.)

Some After-Effects of the Recent Influenza. Read at the meeting of Central New York Medical Association, June 2, 1891. (To be published in Buffalo Medical and Surgical Journal, September, 1891.)

Among the instruments he devised may be mentioned:

Mechanical Nasal Saw.

Self-retaining Nasal Speculum.

Nasal Scissors.

This too brief review of his professional and literary labors shows how earnestly and faithfully he must have worked to attain, at an early age, such an enviable position in the scientific, literary, and social circles in which he moved, and also with what honor and pride he wore the mantle in medicine bequeathed to him by his progenitors.

Personally, Frank Hamilton Potter was a most genial and courteous gentleman, positive in his principles and convictions, but with an agreeable manner of expressing them, which carried weight without giving offense to his associates. His life was as pure and guileless as that of a child. Whether as son or brother, husband or father, he filled the full measure of duty, conscientiously demonstrating his loyalty to principle, his devotion to family and friends, his ambition to excel when excellence could be obtained by honorable means, his aim to combine a commendable zeal for his profession with the equally imperative responsibilities of citizenship, for which his services were sought.

In 1887, after returning from Europe, whither he went for study and travel, he married Eva, daughter of Lars G. Sellstedt, the famous artist of this city, and two sons were born as a result of this union. The widow and these children survive.

The profession join in the general sorrow pervading the community, and tender their sincere sympathy to the afflicted families for this strange dispensation which robs them of a devoted son and brother, a loving husband and father, and the city of a respected and honorable citizen.

T. L.

CIVIL SERVICE EXAMINATION FOR PHYSICIANS.

The advantages to the public at large of appointment to the civil service by competitive examination were never better illustrated than in the examination of physicians for the places of district physicians and sanitary inspectors, lately held in this city. According to the report made to the commission at its July meeting, there were twenty-two applicants, of whom only seven—less than one-third—succeeded in passing. The examination was not a difficult one, and contained only such questions as a well-informed physician should be able to answer. The fact that, of those who succeeded in passing, all but one obtained a high average, proves that the questions were not unfair.

If the same proportion holds good among the rest of the physicians of the city, it is a sad thing for the citizens to reflect upon, that more than two-thirds of our physicians are really unfit for their calling. Such revelations as this show how great need there is for the strict carrying out of the provisions of the new law providing for State examination for license to practice medicine.

Personal.

Doctor A. L. Hummel and Mr. Charles Roome Parmele have formed a copartnership, under the firm name of Hummel & Parmele, for the purpose of carrying on a medical journal advertising agency. The New York office of the firm is at 19 Park place, New York City, and the Philadelphia office at 612 Drexel building, Philadelphia. These gentlemen are both well and favorably known to the medical profession of this country, and we bespeak for them a generous patronage. They are reliable, honest, and energetic, and we wish the new firm a prosperous career.

Dr. Edwin Walker, of Evansville, was elected President of the Indiana State Medical Society, at its meeting in Indianapolis, June 10, 1891,— an honor to him, to his city, and to the young men who supported him so faithfully. He is by many years the youngest man elected to the highest office in the power of the medical profession of Indiana to give. The young men will feel it incumbent on themselves to see that the next year in the history of the Indiana State Medical Society be a memorable one, and that the meeting exceed all others. They will not fail.

DR. JOS. EASTMAN, of Indianapolis, has received the degree of LL. D. from the Wabash College, of Indiana. The doctor is a genial gentleman of deservedly high standing in the profession, and we congratulate him on this high mark of esteem bestowed upon him by those who are in a position to know his worth.—*Lancet-Clinic.*

Society Meetings.

THE AMERICAN SOCIETY OF MICROSCOPISTS. The American Society of Microscopists will hold its fourteenth annual meeting in Washington, D. C., August 10 to 14, 1891.

The Society is composed of professionals and amateurs. The proceedings are extremely interesting, for, in the working sessions, experts give demonstrations of their lines of study; in the evenings exhibits are made of special subjects, and of anything beautiful or instructive any member or exhibitor may desire to display.

Officers.—*President*, Frank L. James, St. Louis, Mo.: *Secretary*, W. H. Seaman, Washington, D. C.: *Treasurer*, A. C. Mellor, Pittsburgh, Pa.

AMERICAN NEUROLOGICAL ASSOCIATION.—The following preliminary programme of papers to be read at the seventeenth annual meeting, to be held at Washington, D. C., September 22, 23, and 24, 1891:

A Case of Polio-Myelitis Anterior—death on twelfth day, with the account of the Microscopic Examination made by Dr. C. W. Burr, by Dr. Wharton Sinkler, of Philadelphia; A Contribution to the Therapeutics of Polio-Myelitis, by Dr. V. P. Gibney, of New York; Polio-Myelitis Acuta Adultorum, by Dr. Wm. C. Krauss, of Buffalo; Double Athetosis, by Dr. Wm. Osler, of Philadelphia; (1) Report, with specimens, of a Case of Multiple Neuritis, (2) Case, with specimens, of Lead-Poisoning, followed by Locomotor Ataxia, terminating fatally by Uremia, (3) Exhibition of a Porencephalic Brain, (4) Report of Two Cases of Rare Myoclonic Disorder, by Dr. James Hendrie Lloyd, of Philadephia; (1) A Case of Thomsen's Disease, (2) Removal of a Neuroma, followed by Disappearance of Local Anæsthesia of fourteen years' standing, by Dr. G. L. Walton, of Boston; A Case of Trephining and Excision of the Cortex for Jacksonian Epilepsy, by Dr. W. W. Keen and Dr. Charles K. Mills, of Philadelphia; The Diagnosis of Certain Forms of Intra-Cranial Syphilis, by Dr. Landon Carter Gray, of New York; Recent Fissural Diagrams, by Dr. Burt G. Wilder, of Ithaca; Syphilis of the Spinal Cord, by Dr. Philip Zenner, of Cin-

cinnati; Lead-Poisoning, with Special Reference to the Spinal Cord and to Peripheral Nerve Lesions, by Dr. E. D. Fisher, of New York; Triple Personality, by Dr. Irving C. Rosse, of Washington, D. C.; A Case of Glosso-Labio-Laryngeal Paralysis, with the Presentation of Specimens, by Dr. Graeme M. Hammond, of New York; The Virile Reflex in Relation to Clinical and Forensic Neurology, by Dr. C. C. Hughes, of St. Louis; (1) Facial Hemi-hypertrophy, (2) Five Recent Cases of Brain Surgery, by Dr. William A. Hammond, of Washington, D. C.; A Case of Tumor of the Cerebellum, in which Trephining was done for the Relief of Pressure, by Dr. Philip Coombs Knapp, of Boston; Lithemia Considered in its Relation to Nervous Phenomena, by Dr. C. Eugene Riggs, of St. Paul

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American Dermatological Association. — The following is the programme of the fifteenth annual meeting, to be held at the Shoreham Hotel, Washington, D. C., September 22, 23, 24, and 25, 1891:

OFFICERS FOR 1891.

President, F. B. Greenough, M. D., of Boston; *Vice-President*, L. N. Denslow, M. D., of St. Paul; *Secretary and Treasurer*, George Thomas Jackson, M. D., of New York.

FIRST DAY, TUESDAY, SEPTEMBER 22D.

Business Meeting (with closed doors) at 9.30 A. M.; Report of Council; Nomination of Officers for the ensuing year; Appointment of Auditing Committee; Proposals for Active and Honorary Membership; Miscellaneous Business.

Morning Session at 10.30 o'clock. — Report of Committee on Nomenclature, and discussion thereon.

PAPERS:

Dermatitis Hemostatica, by Dr. H. G. Klotz; A Case of Lupus Erythematosus with Fatal Complications, by Dr. W. A. Hardaway; Report of a Case of Universal Erythema Multiforme, with colored portrait and specimen, by Dr. L. A. Duhring; An Unusual Case of Sarcoma involving the Skin of the Arm: Amputation: Recovery, by Dr. F. J. Shepherd; Multiple Sarcomata: History of a Case showing Modification, and Amelioration of Symptoms with large Doses of Arsenic, by Dr. S. Sherwell.

SECOND DAY, WEDNESDAY, SEPTEMBER 23D.

Business Meeting (with closed doors) at 9.30 A. M. — Report of Treasurer and Auditing Committee: Election of Officers; Election of Active and Honorary Members: Selection of Time and Place of next Meeting; Miscellaneous Business.

Morning Session at 10.30 o'clock. — Report of Committee on Statistics.

PAPERS:

Discussion of Tuberculosis of the Skin:

Its Clinical Aspects and Relations, by Dr. J. C. White: Its Pathology, by Dr. J. T. Bowen: Its Treatment, by Dr. G. H. Fox: Thirteen cases of Tuberculosis of the Skin, with their Treatment, by Dr. J. S. Howe: A Case of Lichen Scrofulosorum, by Dr. J. Grindon: Notes of a Visit to the Leper Hospital at San Remo, Italy, with Photographs, by Dr. L. A. Duhring.

THIRD DAY, THURSDAY, SEPTEMBER 24TH.

Morning Session at 9.30 o'clock.

PAPERS:

The Treatment of Alopecia Areata, by Dr. P. A. Morrow: A Therapeutic Note on Alopecia Areata, by Dr. L. D. Bulkley: Morphia Atrophia of Wilson, by Dr. R. W. Taylor: The Treatment of Pruritus, by Dr. E. B. Bronson: Prairie Itch, by Dr. L. N. Denslow: Diseases of the Skin associated with Derangements of the Nervous System, by Dr. W. T. Corlett: Treatment of Chronic Ringworm in an Institution for Boys, by Dr. L. A. Duhring.

FOURTH DAY, FRIDAY, SEPTEMBER 25TH.

Morning Session at 9.30 o'clock.

PAPERS:

Notes of a Case of Acute Dermatitis Exfoliativa, by Dr. J. E. Graham: Note Relative to Pemphigus Vegetans, by Dr. J. N. Hyde: A Study of Mycosis Fungoides, with Report of a Case, by H. W. Stelwagon and H. Leffingwell Hatch: Lymphangioma Circumscriptum, with Report of a Case, by Dr. M. B. Hartzell: Remarks on Carbuncle, with Report of a Peculiar Case, by Dr. H. G. Klotz: Note on Erythema et Naevus Nuchae, by Dr. C. W. Allen: A Case of Lichen Ruber, by Dr. J. Grindon: The Personal Equation in Dermatology, by Dr. L. D. Bulkley:

Retirement of old officers and induction of those newly elected: Adjournment.

Book Reviews.

MATERIA MEDICA AND THERAPEUTICS, with especial reference to the Clinical Application of Drugs. By JOHN V. SHOEMAKER, A. M., M. D., Professor of Materia Medica, Pharmacology, Therapeutics, and Clinical Medicine, and Clinical Professor of Diseases of the Skin in the Medico-Chirurgical College of Philadelphia; Physician to the Medico-Chirurgical Hospital, etc. Volume II. of a Treatise on Materia Medica, Pharmacology, and Therapeutics, being an independent volume upon drugs. 8vo, pp. xx.—625. Philadelphia and London: F. A. Davis. 1891. Price, cloth, $3.50; sheep, $4.50.

In reviewing Vol. I. of this treatise, the writer expressed the hope that Vol. II. would be equally as interesting and valuable, and

now since the advent of the latter we have no hesitation in saying that for completeness, originality, and amount of information, we know of no book on materia medica to equal it. This second volume is in itself a complete treatise on the pharmacological, physiological and therapeutical action of the various drugs now used in medicine. Each drug is described in the following manner: Its Latin and English equivalents — are given with a full list of its preparations, together with their doses; then follows a description of the drug and its use externally; its physiological and toxicological actions are briefly reviewed, followed by its therapy. Numerous formulas accompany almost every drug, thus aiding the student in the art of prescription-writing, also in regard to its compatibilities and pleasant vehicles.

Among some of the newer remedies may be mentioned Koch's tuberculin: the dose is given as 1-64 grain hypodermatically; its value is summarized as follows: 1. It exercises a specific and selective action. 2. It is therefore a valuable means of diagnosis as to even the unsuspected existence of tuberculosis in the body. 3. Under its continued action tuberculous tissues are destroyed, and, when possible, are cast off by sloughing. 4. No case of permanent cure has to our knowledge been positively recorded. 5. The large amount of clinical experience already existing warrants the further trial and careful observation of the remedy in tuberculous cases. 6. Even should the future prove the lymph unsuited to permanently cure tuberculosis, the discovery will still remain an index for the future researches in the domain of scientific therapeutics.

An appendix containing formulas for hypodermatic medication adds much to the usefulness of the book.

The typography is similar to Vol. I. W. C. K.

TEXT-BOOK OF HYGIENE. A Comprehensive Treatise on the Principles and Practice of Preventive Medicine from an American Standpoint. By GEORGE H. ROHÉ, M. D., Professor of Obstetrics in the College of Physicians and Surgeons, Baltimore; Member of the American Public Health Association; Foreign Associate of the Société Française d' Hygiene, etc. Second edition, thoroughly revised and largely re-written, with many illustrations and valuable tables. 8vo, pp. x.—421. Philadelphia and London: F. A. Davis. 1890. Price, $2.50 net.

The author of this book attempts the impossible, namely, to make of one work a text-book and a comprehensive treatise. It is a very good text-book, but it is not, by any means, a comprehensive treatise. The arrangement of the work is excellent; the

chapter on the Soil is especially to be commended, as is also that on Hygiene of School.

The chapter on Antiseptics, Disinfectants and Deodorants, is good, except in one particular: it gives no method of liberating chlorine gas for purposes of disinfection after the presence of infectious disease. This is, in our opinion, the only true disinfectant gas for such purposes.

On the whole, the book is to be commended as a text-book, but needs considerable elaboration on the part of the instructor.

DEL. R.

INTERNATIONAL CLINICS. A Quarterly of Clinical Lectures on Medicine, Surgery, Gynecology, Pediatrics, Neurology, Dermatology, Laryngology, Ophthalmology, and Otology. By Professors and Lecturers in the leading medical colleges of the United States, Great Britain, and Canada. Edited by John M. Keating, M. D., Philadelphia; J. P. Crozer Griffith, M. D., Philadelphia; J. Mitchell Bruce, M. D., F. R. C. P., London, Eng., and David W. Finlay, M. D., F. R. C. P., London, Eng., April 18, 1891. Large octavo; pp. viii.—350. Illustrated. Philadelphia: J. B. Lippincott Company. Price, cloth, $2.75; half leather, $3.00.

The object of this periodical, as stated in the preface, is to furnish a complete post-graduate course of medical instruction. The object is a very commendable one, but whether it will bear out the hopes of its editors remains to be seen. Judging from the variety of subjects dwelt upon, and the high rank of the writers, it promises good things. Among the articles treated in the first volume may be mentioned: Acromegaly, by Dr. Ross; Polyemia or Plethora in its Relation to Inflammation, by William Henry Porter, M. D.; Sore Throat, by Christopher Heath, F. R. C. S.; The Treatment of Cough in Phthisis, by J. Mitchell Bruce; Modern Methods in Surgical Operations, by W. W. Keen; Ulcers, by D. W. Cheever; Scirrhus of the Breast, by Chas. T. Parkes; the Early Diagnosis of Pregnancy, by M. D. Mann; Tonsillar Diphtheria, by F. Forchheimer; Different Types of Paralysis in Young Children, by L. C. Gray; Functional Nervous Troubles, by B. Sachs; Neurotomia and Athetoid Spasm, by C. K. Mills; Alcoholic Paralysis, by David Ferrier, etc., etc. The plates and figures are excellent, and aid materially in the usefulness of the book; the typography is faultless.

W. C. K.

MANUAL OF HYPODERMIC MEDICATION. By Drs. BOURNEVILLE and BRICOU. Translated by G. ARCHIE STOCKWELL, M. D., F. Z. S., member of the New Sydenham Society, London. 1890. George H. Davis, Detroit, Mich. Pp. 158. Price, in paper, 25 cents; in cloth, 50 cents. The Physicians' Leisure Library.

The original work by the well-known French authors achieved such success in France that it was deemed advisable to translate it,

so that English-reading physicians could scan its pages. The formulæ of the various medicaments are written according to the English system only, whereas, had both been given, it might have been more desirable. A fact perhaps not very generally known is where absorption takes place most rapidly. According to Lampert, Eulenburg, and Davis, absorption occurs most rapidly when introduced in the temples or cheeks; next, in the epigastrium; third, in the anterior portion of the thorax; fourth, inner side of arm and thigh; fifth, nape, etc.

It makes a convenient little work for reference.

A Treatise on the Diseases of the Nervous System. By William A. Hammond, M. D., Surgeon-General U. S. Army (Retired List); late Professor of Diseases of the Mind and Nervous System in the College of Physicians and Surgeons of New York, the Bellevue Hospital Medical College, the University of the City of New York, and the New York Post-Graduate Medical School and Hospital, etc. With the collaboration of Græme M. Hammond, M. D., Professor of Diseases of the Mind and Nervous System in the New York Post-Graduate Medical School and Hospital, etc. With 118 illustrations. Ninth edition, with corrections and additions. 8vo, pp.—932. New York: D. Appleton & Company. 1891. Buffalo: Otto Ulbrich. Price, cloth, $5.00.

A book which has passed through eight large editions, needs no introduction to the medical profession, no words of praise, and hardly any adverse criticism; the medical public has long ere this reviewed its pages and noted the points of strength and of weakness. This ninth edition has been carefully revised and brought up to the present time by the author's son, Dr. Græme M. Hammond, and consequently stands in the front rank of text-books in neurology.

The Appletons, as is their usual custom, have done their part of the work admirably and deserve no small amount of praise.

W. C. K.

BOOKS AND PAMPHLETS RECEIVED.

The Genuine Works of Hippocrates, translated from the Greek, with a Preliminary Discourse and Annotations. By Francis Adams, LL. D., Surgeon. Octavo, 766 pages, extra muslin, gilt top, price, $5.00. New York: William Wood & Company.

A Clinical Text-Book of Medical Diagnosis for Physicians, based on the Most Recent Methods of Examination. By Oswald Vierordt, M.D., Professor of Medicine at the University of Heidelberg, formerly Privat-Docent of the University of Leipzig; later Professor of Medicine and Director of the Medical Polyclinic of Jena. Authorized translation from the second improved and enlarged German edition, with additions. By Francis H. Stuart, A. M., M. D., New York. With 178 illustrations, many of which are in colors. 8vo, pp. xvi.—700. Philadelphia: W. B. Saunders. 1891. Price, cloth, $4.00 net; sheep, $5.00 net.

The Surgical Treatment of Wounds and Obstruction of the Intestines. By Edward Martin, M. D., Instructor in Operative Surgery, University of Pennsyl-

vania, Surgeon to the Howard Hospital, Assistant Surgeon to the University Hospital; and H. A. Hare, M. D., Professor of Therapeutics, Jefferson Medical College; Attending Physician to St. Agnes' Hospital. Fiske Fund Prize Dissertation. No. XL., 8vo, pp.—169. Philadelphia: W. B. Saunders. 1891. Price, cloth, $2.00 net.

Insomnia and its Therapeutics. By A. W. Macfarlane, M. D., Fellow of the Royal College of Physicians, Edinburgh; Fellow of the Royal Medical and Chirurgical Society of London; Examiner in Medical Jurisprudence in the University of Glasgow; Honorary Consulting Physician (late Physician) Kilmarnock Infirmary; Formerly Examiner in Medicine and Clinical Medicine in the University of Glasgow, etc., etc. Reprinted from Wood's Medical and Surgical Monographs. Octavo, 302 pages; muslin, $1.75. New York: William Wood & Company. 1891.

Practical Intestinal Surgery, Vol. I. By Fred. B. Robinson, B. S., M. D., Professor of Anatomy and Clinical Surgery, Toledo (Ohio) Medical College; *Physicians' Leisure Library*. Issued monthly. Detroit: George S. Davis. 1891. Price, cloth, 50 cents; paper, 25 cents.

Lectures on Tumors from a Clinical Standpoint. By John B. Hamilton, M. D., LL. D., Professor of Principles of Surgery and Clinical Surgery, Rush Medical College, Chicago, and in the Chicago Policlinic; formerly Supervising Surgeon-General U. S. Marine Hospital Service, etc., etc. For the use of students. *Physicians' Leisure Library*. Detroit: George S. Davis. 1891. Price, cloth, 50 cents; paper, 25 cents.

Annual Report of the Superintendent of Education of the City of Buffalo. By James F. Crooker. 1889-90. Buffalo: Haas & Klein. 1891.

Annual Report of the Board of Managers of the Buffalo Historical Society, January 13, 1891, and the Society Proceedings. Buffalo: Published by order of the Society. 1891.

Three Communications to the Tenth International Medical Congress. By Paul Gibier, M. D., Director of the New York Pasteur Institute. 1. A New Theory about Temperaments. 2. Peroxide of Hydrogen; Ozone—Their Antiseptic Properties. 3. On Hydrophobia.

Nineteenth Annual Report of the Board of Inspectors of the House of Correction of the City of Chicago, for the year 1890. Presented by Mark L. Crawford, Superintendent.

The Chair of Surgery in Rush Medical College. By N. Senn, M. D. Ph. D., Professor of Surgery in Rush Medical College; Attending Surgeon to the Presbyterian Hospital. Introductory Address before the Class, April 11, 1891. Reprint: *Journal of the American Medical Association.*

Ueber Schwangerschaft nach konservativer Ventrofixatio uteri retroflexi. Von M. Sänger. (Vortrag, gehalten in der Sitzung der Gesellschaft für Geburtshülfe zu Leipzig, vom 16. März 1891.) (Sonder-Abdruck aus dem Centralblatt für Gynäcologie, 1891. No. 16.)

A Knowledge of Time Requirement. A Plea for a More Rational System of Medical Legislation. By Young H. Bond, M. D., Dean of the Marion-Sims College of Medicine, St. Louis, Mo. Reprint: *The Weekly Medical Review*, April 25, 1891.

Thirtieth Annual Report of the Cincinnati Hospital to the Mayor of Cincinnati, for the fiscal year ending December 31, 1890.

Pepsin. A Review of the Pepsin Question. By Dr. Carl Frederick Witte. Reprint: *Notes on New Remedies*, February and March, 1891.

Hypertrophy of the Pharyngeal Tonsil. A Clinical Lecture delivered October 30, 1890. By E. Fletcher Ingals, A. M., M. D., Professor of Laryngology in Rush Medical College, Chicago, Ill. Reprint: *The Medical News*, March 21, 1891.

The Shurly-Gibbes Treatment of Tuberculosis. By E. Fletcher Ingals, A. M., M. D., Professor of Laryngology in Rush Medical College; Professor of Diseases

of the Chest and Throat in the Woman's Medical College; and John Edwin Rhodes, A. M., M. D., Professor of Diseases of Chest and Throat Clinic, Woman's Medical College. Reprint: *The Chicago Medical Record*, April, 1891.

The Surgery of Cleft Palate. By M. B. Ricketts, M. D., Cincinnati, O. Read before the Mississippi Valley Dental Society. March, 1891. Reprint.

Miscellany.

MALTINE.—A striking feature of the new advertisement of this nutritive tonic, on cover page iv., is the design of a Maltese cross, in which the play on the word "Maltine" will be noted. It was under the banner of the Maltese Cross that the Crusaders of the middle ages vanquished the followers of the Crescent, and this form of cross was adopted by the hospitallers of the Order of the Knights of St. John of Jerusalem, who were among the first founders of institutions established to ameliorate the physical ills of mankind. After their occupation of the Island of Malta, which they held for centuries against the assaults of the Infidel, this symbol came to be known as the "Maltese Cross." It is emblematical of the success of merit, of practical benefit to mankind, and of ability to resist attack. The appropriateness of the use of this design in connection with a valuable or constructive nutrient tonic, is therefore apparent.

AN OPEN COMPETITIVE EXAMINATION of candidates for Junior Assistant Physician in any of the State Hospitals and Asylums, will be held at the office of the Civil Service Commission, Albany, N. Y., Thursday, August 20, 1891, commencing at ten o'clock A. M. A candidate for the position must be a citizen of the State of New York, at least 21 years of age, and have had at least one year's experience in a hospital, or three years' experience in the general practice of medicine. For application blanks, address the Secretary of the New York Civil Service Commission, Albany, N. Y.

JOHN B. RILEY,
Chief Examiner.

ALBANY, N. Y., July 3, 1891.

NOTICE TO CONTRIBUTORS. — We are glad to receive contributions from every one who knows anything of interest to the profession. Articles designed for publication in the JOURNAL should be handed in before the first day of the month. The Editors are not responsible for the views or opinions of contributors. All communications should be addressed to 284 FRANKLIN STREET, BUFFALO, N. Y.

Buffalo Medical and Surgical Journal

Vol. XXXI. SEPTEMBER, 1891. No. 2.

Original Communications.

SOME AFTER EFFECTS OF THE RECENT INFLUENZA.[1]

A POSTHUMOUS PAPER

By FRANK HAMILTON POTTLE, M. D.,

Clinical Professor of Laryngology in the Medical Department of the University of Buffalo. Surgeon in charge of the Throat Department, Erie County Eye, Ear and Throat Infirmary.

The invitation of your president to present a paper at this meeting was accompanied with a request to make it a short one. My remarks, therefore, under the title that has been selected, will be more in the nature of an introduction of the subject than an exhaustive or detailed report.

Whatever may be our views of the nature of the recent influenza, we are sure of certain observations concerning it. It has an epidemic character and impresses itself, sooner or later in its course, upon the air passages. It is not a simple cold, but has a distinct individuality. What this may be, must be determined by further investigation, when a larger experience will give us more complete data upon which to base some general conclusions. At present we are concerned in calling attention to certain results which, either from the violence of the inflammatory processes or from the nature of the disease itself, continue after the disease has disappeared. These results are seen in the general depressed condition of the nervous system; in inflammation in and about the ear, and in subacute inflammatory laryngeal disturbances. Again, those who before having the influenza did not suffer at all from catarrh of the upper air tract, now appear with various forms of that disease. They will at once inform you that their trouble dates from *la grippe*. Others who had some slight trouble before, now exhibit the catarrhal manifestations in

1. Read at the meeting of the Central New York Medical Association, Buffalo N. Y. June 2, 1891.

forms much more severe. So we can easily see, besides the damage attending the disease itself, that there is a long list of after-effects that require careful treatment.

Let us first consider the disturbances seen in and about the ears. These consist of middle ear inflammatory changes of all degrees. Occasionally, where the inflammation has been especially severe, we also observe changes in the external auditory meatus. One case came under my observation with the history of recurrent attacks of median otitis. They were mild at first, and after each attack the patient thought there would be no more trouble. Finally, a purulent catarrh developed, the membranous tympanum was partially destroyed, the external auditory meatus nearly occluded, and there were symptoms of involvement of the mastoid cells. Happily the result in this case was favorable, but it illustrates very well not only the insidious character of the effects of the influenza upon the ear, but also the danger of neglecting to properly interpret the symptoms when first seen. Another case was seen with an acute catarrhal inflammation of the middle ear, which appeared promptly after the subsidence of the general symptoms of influenza. The disease developed so rapidly as to cause perforation of the drum ; it was very persistent, the patient making a slow, though good recovery. Again, several instances of acute catarrhal otitis without perforation have been seen, and also one case of inflammation of the external auditory meatus without involvement of the middle ear. We can thus see that the effects upon the ear may be as severe in this disease as in any of the exanthemata or general febrile diseases. The conditions of the auditory apparatus should be noticed, therefore, in all cases, so that prompt measures can be employed in order to prevent any permanent mischief.

In the nose some interesting conditions are seen. Patients who, previous to the attack, considered themselves free from what they call " catarrh," now begin to complain of some of the symptoms of that many-sided disease. If true that there has been no previous disease, we usually find in the nose the condition described by some authors under the term of simple chronic rhinitis. This is probably one of the very few opportunities we have of studying this condition. It is seldom seen by itself,—that is to say, without hypertrophic changes being also present. It is an inflammation of a mild but persistent type, not involving the connective tissue, and therefore not showing evidences of hypertrophy. It may be, and is so considered by some writers, as the first step in hypertrophic

catarrh. It is distinguished by the resistance of the tissues under the probe, and the complete contraction of the tissues under cocaine. Its prominent symptoms are persistent stenosis with copious secretion. It is relieved by antiseptic washes with astringents. In severe cases applications of chromic acid are indicated.

In cases of old standing catarrh with hypertrophic changes, and with or without bony deformity, we find that the influenza has usually produced a marked aggravation of all symptoms. Many cases of this sort that have come under observation the past Winter and Spring, could be cited in illustration of this statement, but too many details of cases are wearisome and consume time; and, besides, my purpose will be served if this proposition will receive the attention it deserves. In the naso-pharynx and pharynx, especially in the former, we find some after effects that require to be noted. The glandular structure in the naso-pharynx seems stimulated to great activity by this peculiar epidemic, and as a result we have the disease called naso-pharyngeal catarrh. This differs very much from a chronic nasal catarrh on account of the difference in the naso-pharyngeal tissue. Without discussing what this difference is, we may state that inflammatory action here may take one of two directions: either there may be an increase of the glandular structure, or stimulation of the activity of the glands with destruction of the epithelium. In the one case we have so-called adenoid development; in the other an abundant and persistent muco-purulent discharge. In my experience the influenza was followed by the latter form of disease when secondary results were observed in the naso-pharynx. In these cases the nasal tissues were but little effected, the trouble being confined to the pharyngeal vault. They exhibited many of the characteristics of an old catarrhal trouble in this region, and it did not seem correct to give the disorder such a recent date. The patients, however, were reliable, and assured me that previous to the influenza they had been free from any nose or throat disease.

In this condition we would be interested, naturally, in observing whether the tonsils showed any evidence of being also involved. Two such cases were seen. The tonsils could not be said to be acutely inflamed, neither would the local nor constitutional symptoms warrant this. But they were rather subacutely inflamed, if I may so speak. The follicles were filled with secretion, and the tonsils were swollen, red, and tender. There was some difficulty in swallowing, in speaking, and in respiration, though not

sufficient to cause any anxiety. One case had some rheumatic history; the other showed no such constitutional disturbance.

In another case edema of the uvula was seen. This was in an infirmary patient in the service of my assistant, Dr. Henry J. Mulford. The patient did not return, so that nothing beyond the fact of the edema being present, and its dependence upon *la grippe* can be given.

Another sequel was the formation of a small abscess in the tissue between the last molar tooth and the tonsil. There was some suspicion of disease of old standing in the tooth, but this was not clearly made out. Two months after recovery I saw the patient, who said the tooth had not been treated up to that time, and had given no trouble since.

I have seen several cases of laryngitis following the influenza. These were attended by loss of voice, usually partial, but in one case almost complete, with pain and cough. The latter was very persistent and of a dry, irritating character. It was difficult to control. In two instances the cough was so severe, and the paroxysms so prolonged, as to greatly exhaust the patients. The larynx was usually found deeply congested, especially along the vocal cords and about the arytenoids. There was not much apparent swelling, but the articulations must have been involved, as any movement caused pain. To the eye also the action of the larynx seemed halting and uncertain.

Nothing has been said about the treatment of the conditions thus passed in review — perhaps altogether too briefly. The purpose has been simply to notice those after-effects that have come under my own observation. For this reason, also, no reference has been made to the literature, already rapidly accumulating, relating to this disease and its effects upon the air passages.

Passing down into the chest we find bronchial and pneumonic complications of the inflammatory type. Pneumonia following *la grippe* usually has been fatal. Cases of this character must have come under the observation of almost everyone present, and reference is made to it merely to complete the list, so far as the writer is concerned, of the after-effects of the influenza as seen in the air tract. There may be other secondary changes, but all those have been mentioned that have fallen within my experience. The list of authors who have called attention to these sequelæ is already large. It would be instructive to compare their views, which may be done on some other occasion.

We can see, however, from this short account, based though it be upon a limited experience, that the influenza, prevalent during the past two years, is prone to leave behind it some disorder of the air tract that is important and may be serious. We conclude, therefore, that the disease should be watched for any of these late manifestations, the patient warned against too early exposure, and informed of the importance of prompt treatment, should any of the above-described complications arise.

DUTIES OF PHYSICIANS AS EXAMINERS FOR LIFE INSURANCE.[1]

By GEORGE L. BROWN, M. D.,

Medical Director of the Masonic Life Association, of Washington, New York.

History informs us that the plan of life insurance had its origin in England in the sixteenth century. It began with what were called friendly societies, and its beginnings were, of course, crude and experimental. At first the payment only of small sums for burial expenses, or for annuities to widows of clergymen, was attempted. Benevolent societies, with similar objects, which have been enlarged from time to time, have existed in America almost from the beginning of its settlement. Their growth has been marvelous, and the good they have accomplished, and are still effecting, is incalculable.

But the failures have been many, and have very clearly demonstrated that success can be had only by adherence to business principles. To be successful, the assessment or premium must be carefully adjusted to the risk, and the risk cannot be intelligently estimated without scientific investigation. Low assessments are possible only with low mortality, and it is only with low assessments that the coöperative associations can compete successfully with innumerable other companies that are seeking business.

Until quite recently applicants were received as a matter of charity, or fraternity, and without medical examination. But it very soon appeared that the losses were so heavy that the survivors could not and would not meet the necessary assessments. Good fellowship, mutual aid and sociability are well in their place, but will not, nor should they, make an applicant for insurance pay more for it than it is worth. It becoming clear that the existence

1 Read before the sixteenth annual convention of the Mutual Life Insurance Underwriters, at Minneapolis, Minn., June 16, 1891.

and prosperity of the associations depended almost entirely on the contingencies of health and life, physicians were called upon to make such examinations as should detect the diseased and unhealthy, and it has clearly appeared that their services are indispensable.

Their duties are delicate and important. A single mistake from careless or insufficient examination may cost the assessment payers thousands of dollars. And it must be confessed that such mistakes are not uncommon. That is but too clearly apparent from our mortuary tables. Among the causes of death of persons who have been, only a few months before the deaths occur, accepted by the most skilful and careful physicians, we find consumption, organic disease of the heart, cirrhosis of liver, uremic poisoning, diabetes, cancer of the various organs, cystitis nephritis, Addison's disease, etc. Great injustice has been done, and daily is done, to the associations and companies, and to applicants, by the hurried and insufficient manner in which examinations are made. That such should be the case is doubtless a reproach to our profession, but we think the responsibility for it lies principally upon the management of the companies. Much too often they are willing neither to pay a fair price for the thorough examination of applicants, nor afford suitable opportunities and facilities for making it.

The great competition that exists among all classes of life insurers has led to very unfortunate and undesirable practices. Not only the coöperative, but both the stock and mutual associations, expect and require their doctors to visit an applicant at his factory, store, counting-room, or residence, and, if fortunate enough to find him, to undertake the duties of a canvasser, and argue the claims and merits of their respective schemes. If successful in convincing him of them, he is then and there to make his professional examination, in the presence of others and amidst the noise and confusion of rattling machinery, musical instruments, type-writers, or children.

And not infrequently he is called upon in the lodge room to examine a large number of charter members in a single evening, and in the presence of each other. How does, and under such circumstances, how must he perform his work? By counting the pulse, looking at the tongue, taking the measurements and listening to the heart and lungs through ordinary clothing. And he is paid for the examination that he makes, the sum of from one to five dollars, according to the fixed rules of the association or company. Is it not apparent that such investigation is necessarily superficial

and insufficient, and that in such practices is to be found the reason why the death losses are, in many of our associations, so heavy and so out of due proportion to the assessments that have been expected to suffice? The matter is one of sufficient importance to call for the most careful and thorough exercise of professional skill. Nothing less than that should be accepted, and the payment made should be commensurate with the value of service required. The physician should practice what he has been taught, —"to see with his own eyes, feel with his own hands, and hear with his own ears." In justice as well to the applicant and the company as to himself and his own professional reputation, he should conduct his examinations only in his own office. The applicant should disrobe. His exact height and weight should be taken, and their proportion to each other accurately noted. Thorough investigation should be made as to indications of dietic, parasitic, diathetic, and genetic diseases.

Very many diseases of the chest and abdomen, acute as well as chronic, can be detected by changes in the color of the skin from its normal appearance. It has been truly said that a man who has a perfectly healthy skin is almost certain to be healthy in other respects. The examiner should observe whether the skin be dry or moist and clammy, pale, blanched or livid, jaundiced, or of that dull, earthy hue which at once gives the impression of serious organic disease, associated with disordered nutrition and emaciation, cyanosis, emphysematous or sclerotic affections.

The general character of the constitution, whether vigorous or otherwise, should be carefully noted. Particular attention should be given to the form and development of the chest, whether enlarged and bulging, or contracted and depressed in particular places. The form and position of the sternum, clavicle and ribs should be noted, and traces looked for of pleuritic effusion or absorption of pleuritic exudation, or of caseous degeneration or tuberculosis of the lungs, and search made for indication or vestiges of rickets and diseases of the vertebral column. The movement of respiration, its extent and frequency, must be watched, and a complete inspection and palpation of the abdomen will be of vast importance in many cases. The temperature of the body must be duly recorded, and as in healthy persons that is subject to daily fluctuation, rising continually from morning to evening, and sinking again until morning, the hour of the day when the examination is made should be noted.

Exercise, according to its violence and duration, raises temperature; the taking of food and drinks has a similar effect which should not be overlooked, but carefully estimated. In examining the lungs, heart, and liver, the physician cannot exercise too much care. Many cases of pulmonary tuberculosis in its incipient stage can be detected by cautious scrutiny, in which one is much assisted by certain marked characteristics, such as large eyes, long eye-lids, thin slender hands, curved nails and leanness of the chest, that indicate a predisposition to the disease, when it cannot be discovered by other means. The sounds of the heart and general phenomena of the circulation should be carefully examined and recorded. The liver and the condition of the primæ viæ and digestive system should be accurately examined. The urine, which is the product of eliminative action in the body, should always be voided in the presence of the examiner, and the applicant can usually succeed in inducing a flow of it by immersing his hands in cold water. It should be analyzed before it has stood long enough to undergo a chemical change. And here the question arises, How far should the examiner proceed with his analysis? At present our companies require only tests for albumin and sugar, provided the specific gravity and color are nearly normal and the reaction acid. If there is albumin or sugar present, the risk is generally disapproved. But it is very questionable whether that is just in every case. It is well understood that shortly after one has partaken freely of highly albuminous food, albumin is to be found in his urine, although his health is perfect. The same is true as to sugar after an excess of saccharine food. Here permit me to quote from Henry S. Millard, M. D.: "Should all cases of chronic albuminaria, simply from the fact of albumin being found, be rejected by life insurance examiners?" He says they should not, "as he has known some albuminuric patients who enjoyed practically good health, and lived to a good old age." "Albuminuria is not always a more threatening symptom than other symptoms; an albuminuric patient may occasionally be in every respect a good risk." "There are cases where repeated and comprehensive examinations must be made before the examiner can decide as to the interests of his company." There can be no unvarying rule as to this point. He has known albuminuric subjects rejected whose health was good, and applicants with other affections much more serious than some of these cases accepted.

I have myself known persons with sugar in their urine who

have enjoyed good health and outlived their expectancy, according to our expectancy tables, and still they could not be accepted as fair risks under our rules. I believe that the examiner should proceed further than those rules direct, and make analysis for bile pigments, corpuscles and epithelial casts. It is highly important that in the examination of every applicant, some blood should be drawn and submitted to careful scrutiny and to microscopical inspection. The color and number of both the red and the white corpuscles, and the proportion as well as the character of the constituents of the fluid should be noted. Almost all diseases of the rectum and anus are called "piles" by the majority of people. How many of the physicians of life insurance companies ever examine an applicant to ascertain whether he is afflicted with piles, fistula, pruritus, polypi, fissures, warts, ulcers, prolapsus, proctitis, or cancer of the rectum? But to fail to do so is to commit a great injustice.

It appears to me to be very clear that the examining physician of every assurance society, or company, should be expected and required to examine all applicants in a private, quiet place, where he can have the convenient use of all necessary instruments and appliances. He should have at hand a tape line, fever thermometer, stethoscope, stethometer, spirometer, cyrtometer, a percusser and plexiimeter, tuning fork, cardiometer sphygmograph, tongue depresser, urethral sounds, rectum and ear speculums, microscope, urinometer, test tubes, reagents and pipettes, litmus paper, laryngoscope, throat mirror, and scales.

A thorough examination and record should be made in regard to the family history, resemblances and predispositions, habits of life, occupation and nationality of those who are connected by ties of consanguinity, or marital relations with the applicant: his own habits in regard to the use of stimulants, narcotics, tobacco and patent medicines, should be noted. His general appearance, the scars of previous vaccinations, the history of all diseases that he has suffered from, scars, defects and special marks, his peculiarities as to having large or small bones, his temperament, the color of his hair and eyes, and everything pertaining to his health and the prospect for it, should go into the record. And it is important that the record be made by the examiner, in his own handwriting, and not, as is now customary, by a solicitor or agent. If I seem to you to have outlined a pretty wide field of professional duty for the medical examiner, I can only ask, What part of it can with safety be omitted?

Our associations, to succeed, must strictly adhere to the business principle of maintaining only such mortality rates as our assessments will justify, and our assessments are limited by competition. The theory that we are simply charitable institutions and exempt from the restraints of business rules, has necessarily been abandoned. If it had not been, all medical examinations should either be dispensed with or reversed so that their aim should be to discover the most diseased and precarious cases, as such are certainly the most needy objects for charity. If we are to have any scientific scrutiny of applications, let us have something that will give a firm basis for intelligent judgment. Anything short of that is a reproach to the medical fraternity and dangerous to the association. To save the loss occasioned by improper acceptance of a single application, followed in a few months by a death that results from a discoverable disease, is to have the cost of many such examinations as have been described? And, on the other hand, they might prove that cases now rejected are perfectly good, and our associations cannot be maintained without the constant influx of good cases.

173 NIAGARA STREET.

CONCENTRATED FOOD IN THE TREATMENT OF PULMONARY CONSUMPTION.[1]

BY THOMAS J. MAYS, M. D.,

Professor of Diseases of the Chest in the Philadelphia Polyclinic; and Visiting Physician to the Rush Hospital for Consumption, of Philadelphia.

CALLING attention to the importance of nourishing diet in the treatment of pulmonary consumption, is so trite that it barely deserves repetition; yet, old as it is, it is no less true today than it ever was. Indeed, it may be laid down as a fundamental proposition, that the cases of consumption which cannot be reached through the instrumentality of food have certainly slim prospects of recovery. It is also no less true on the other hand that if your patient can be made to partake of, digest, and assimilate a sufficient amount of food, it matters little in what condition his lungs may be, he will, with ordinary good management, make a good recovery in the great majority of instances. Failure to get well under these circumstances is the exception. To make your patient eat, then, is the great problem to solve in the cure of this disease, yet everyone realizes the enor-

1. Abstract of a lecture delivered at the Philadelphia Polyclinic.

mous difficulties which are constantly placing themselves in our way. Very little can be done to attain this end by only addressing medicines to the stomach. You are required to rise higher than this, and to take a general survey of the whole condition of your patient. In other words, it is absolutely indispensable that you should regulate his exercise, his rest, his sleep, and his eating; in fact, you must have a systematic supervision of all he does during the whole twenty-four hours. I arrived at the conclusion, long ago, that a consumptive patient who is fatigued cannot eat. So, his appetite will greatly depend on how much or how little exercise you prescribe for him. If much exercise tires, then less must be taken, and if little exercise tires, then absolute rest must be insisted on. Many of these poor people exercise themselves to death. Digestion, like exercise, requires a certain degree of bodily strength. The strength which is expended in performing exercise deducts so much from the sum total of the bodily forces, and in most cases leaves too small a residuum to carry on the processes of digestion, absorption and assimilation, and is the principal cause of the persistent anorexia. I am well aware of the prevalent impression that exercise is one of the essential promoters of a good appetite, but all you need to do is to ask your patient to give you an opportunity to demonstrate the falsity of this belief by a prolonged dose of rest, and I dare say that a single chance will be sufficient to dispel the illusion. Rest will not only restore his appetite and save his strength, but it will reduce his fever, diminish the cough, and make him feel more comfortable in every respect.

If your patient eats, what kind of food should he have? It is that kind which concentrates a large amount of nutritive material in a small bulk, and which requires a small amount of digestive energy on the part of the stomach and the digestive tract. Such foods exist, without question, in the freshly prepared juice of beef, oysters and clams, and they are prepared as follows: Beef, preferably the roundsteak, is cut in pieces of the size of a walnut, and is placed in a pan and held over the fire for a few minutes in order to heat the outside slightly. The whole is then dumped into a large Bartlett beef press, and this separates the juice from the fibre. About one and one-half pounds of beef will yield a teacupful of beef juice. This juice, divested of all fat, is well seasoned, and taken cold in half teacupful doses, three or four times a day. In the case of oyster and clam juice, the same process is followed in extraction, and it is likewise taken cold and seasoned. These juices

contain the very essence of nourishment, require very little or no digestion, are easily absorbed and assimilated, and may be administered to the most fastidious stomachs. They are very much superior to any kind of beef tea, or extract, that can be made. Additionally, I prescribe five or six glasses of milk a day. Much may be done in feeding these patients by going about it in a systematic manner. Begin at seven o'clock in the morning with a glass of milk, and repeat the same every three hours. If a whole glass is too much, be satisfied if only half a glass is taken at first. At eight o'clock administer half a teacupful of beef juice. At first this is given three times only, but as soon as possible, four times a day. If desirable, oyster or clam juice may be substituted once during the day for the beef juice. Besides, you must persuade your patient to eat an egg, or oatmeal gruel, with cream and sugar, and bread and butter, and a cup of coffee for breakfast; beefsteak, roast beef, mutton or lamb, with vegetables, for dinner, and a lighter meal for supper. Beer, wine, champagne, whisky, or brandy may also be taken in moderate quantities throughout the day.

Much can be done to stimulate the appetite; for this purpose I often give the following: R. Acid phosphoric dil.; acid nitro-muriatic dil.; acid sulphuric aromatic; tinc. ferri chloridi, aa fl℥ss. M. Sig. thirty drops in half a glass of cold sweetened water during meals. A coated tongue, which so frequently exists in these cases, is no contra-indication to the giving of iron. Additionally, two or three grains of quinine are prescribed in the forenoon and in the afternoon. The bowels must also be kept regular. If constipated, a glass of Hunyadi water, or a Lady Webster's pill in the evening, will generally suffice. Topliff's pavara pills, or Parke Davis & Co.'s cascara cordial, also serve well for this purpose. Occasionally, a blue mass pill will not be out of place. If there is a tendency to diarrhea, the above-mentioned acid preparation will often check it. In most instances of this kind, the diarrhea follows a meal, and is due more to a hyper-sensitiveness of the alimentary tract than to any other cause. To the acid mixture you may, therefore, add subnitrate of bismuth and pepsin with advantage.

Mastitis. In the Columbia Hospital for Women (*Obs. Gaz.*) a liniment composed of half an ounce of camphor dissolved in three ounces of turpentine has been found most effective in checking the secretion of milk in mastitis; it alleviates pain, lessens induration, and is more effective in reducing inflammation than any other remedy that has been tried.

Society Proceedings.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, May 11, 1894.

The Vice President, Dr. Forest Willard, M. D., in the chair.

Dr. Joseph Hoffman submitted a paper on

THE RELATION OF IMPERFECT SURGERY TO THE SEQUELÆ OF PELVIC AND ABDOMINAL OPERATIONS.

So much has lately been said and written relative to the results and, therefore, to the justifiability of abdominal and pelvic operations, that it is necessary for the candid critic and honest operator to stop and consider what, on the one hand, is the exact status of the repentant critics and of their changed attitude toward the position and merits of surgery, and on the other how far inexact methods are accountable for some of the failures and misfortunes of what would otherwise be a field of almost unprecedented brilliancy and encouragement, in the results that have been obtained in this branch of surgery.

In the first place it is to be noted that of all the men who have gained prominence in any of the various domains of surgery in general, not one has abandoned that specialty from a surgical standpoint in order to treat it empirically by any other method. Sir Henry Thompson, for instance, has not departed from the exact surgery of the bladder in order to destroy its calculi by solvents or electricity; Mr. Macewen, bone surgery; or Shaffer, orthopedics. What is meant to be here illustrated is, that when a man has once chosen a specialty and worked up to that specialty by an experience gained by natural selection and application, his specialty has become so much a part of him that its abandonment is just as impossible as the negation of the laws of gravity. His training makes it the law of his mental gravity, and the same laws apply to it as to weight and inertia in the physical world. The greater his experience, the longer his training, the more certain is he in regard to the limitations, the requirements, the possibilities of his work, and as a result of all this his position, when taken, is an entrenched one, from which he is not to be moved and made a weathercock of every shade of opinion, whether of madmen, fools or philosophers; for none of these are apt to speak from a practical experience, in

surgery at least: and practice, not theory, has made surgery what it is.

That there are specialties in surgery has come about by the consensus of opinion among surgeons in general, and physicians, strictly so-called, that there is need of them. The specialist in any branch is the living embodiment of the necessity of his work. To whom then is the title of "specialist" to be applied? In each branch confessedly, to those who work conformably with their expressed sentiment; or if not, teachers whose line of procedure is uniform and the result either of their own experience wrought out by laborious painstaking, or conforms with that of other expert workers in the same line.

To that class of see-saw workers who anon are this and anon are that, the name specialist should not be applied. For accurate, exact surgery, we cannot look to the electrician or the dabbler in it. If one condemns a procedure today and extols it tomorrow, we are brought to the point of inquiry, Which view is correct, which has the vantage of observation? or perhaps, Is either expression of any value whatever? or, Is the change made like that of the sleight-of-hand man to puzzle his audience and bring in a set of new admirers to be pleased by the rare and startling exhibition of surgical acrobatics,—a surgery in which the constant is differentiated out of sight by the variable?

These inquiries and lines of thought are suggestive of some of the causes we have to consider in the relation of imperfect work to the sequelæ of abdominal and pelvic surgery. What has been said of experience as a necessity for a firm faith in the necessity of any special branch of work, is true with just as much force when the ability to do such work is considered. The appalling eagerness with which men with only a diploma as a justification and a safeguard from the hand of the law to do abdominal surgery, is one of the startling features in the history of this work. In no other branch of the art has there ever been any approach to such audacity. That fools rush in where angels fear to tread has never been more aptly illustrated. Training has been,—nay still is—rejected, while the work is sought, and if the case is found willing to be offered up an offering to the prurient itch of a surgical pretender, the case is at once reported as a wonderful cure in the hands of the youthful aspirant; or if unsuccessful is recorded, heralded, and posted up as a warning against all surgery in general, and against that surgeon in particular who has been rash enough to loan both his instru-

ments and experience to a neophyte, with no other experience than in-grown toe-nails and vaccination, now hiding and excusing himself and his failure behind the experience of the too easy friend, who by a mistaken kindness has martyred both himself and surgery, and done both an irreparable injury. I take it that it should be the rule of all surgeons to assist no one who has not studied, observed and assisted in such work. There is no excuse or reason here for men to begin with all the faults and errors of the early operators, and again work out the technique of this branch of surgery in a series of failures and calamities that once well-nigh led to its abandonment. The work of such men cannot be other than imperfect, and must reflect upon surgical interference in these affections in the minds of the uncritical and unthinking. Another class of operators to be carefully watched, is one which, by fair means or foul, is bound to attain prominence. These men have lain in wait for operations, as the moonshiner for a cloudy night, to bring themselves into prominence, let us say notoriety. These men have opened abdomens, not to operate, but to do the first step of an operation. I can this moment put my hands on such a case, in whom nothing was found wrong, but there was a chance to perpetrate a pet fad, and the woman is now dragging out an existence after three subsequent operations, all the result of the first unnecessary tinkering. If we are to criticise abdominal surgery, let us not do so with the results of such operators and their methods before our eyes. Let us rather criticise the crude methods and cruder morals, or, if you please, the code that tolerates apprentices and dabblers to do with the bodies of our patients the like of which would ruin the reputation of our tailor, or well-nigh mob a cobbler. That such surgery has been overdone is just as true as it is that it has no right to be considered surgery at all. And just here it is to be said that among men of this class, I mean those who have done the kind of work just referred to, we are bound to find our latter-day conservatives and repentants. Of all those who have gained and kept a name as foremost in the rank of abdominal surgeons, we find no recanters. These are almost always to be found in the lines of failure, or discouragement, or embarrassment. If a man has made blunders, he is a fool not to perceive them, or if the real spirit of surgery is beyond him, and he feels it, he alike is bound on the one hand to retrieve past misfortune by so called conservatism, sitting on the *pons asinorum* watching the stream of surgery flow by, and with it the hopes that he no more has chance

of realizing. On the other, having neither the spirit of surgery within him, nor the courage to attain it by drill and application, nothing is left for him but to be a dissenter, to decry all surgery as mutilation, nothing justifying but conservatism. From this standpoint I make the plea that each one of us, before he condemns surgery, its justifiability or its results, shall judge of them all. As sensible men and women, saying that we are in need of surgical attention, to whom shall we go? To the apologists for their work, to those who have operated themselves into repentance, who have made an experience only to regret it? Certainly not. Experience and judgment in this work is no more to be gotten in lumps, than can knowledge be bought by the wagonload of books.

If there has not been an antecedent experience from which special knowledge has been differentiated, this special knowledge, though it may be wide enough theoretically, practically is cramped and dwarfed. The wider the general experience, the more exact will be the special. Having considered the class of operators we must look to for errors and repentance, let us look at the work as surgery simply, not in the light of miracles it is supposed and often promised to work. Miracles nothing human can perform. No surgeon has a right to promise an absolutely certain result in every case. I have too frequently heard promised, "The operation will make you a well woman!" Patients are persuaded into operation when they should be left to choose it for themselves. I have nothing but condolence, may be contempt, for the surgeon who has to persuade his patients to be operated upon. Herein comes a great deal of the blame of surgery in the abdomen and pelvis. Who ever heard of a surgeon's having to persuade a patient to put a splint upon a broken leg or a ligature around a bleeding vessel? The indications for every operation should be plainly stated, and the patient or her responsible friends be responsible for the decision for or against operation.

The disasters of operation, on the other hand, ought not to be attributed to the inherent danger of abdominal or pelvic interference. We are to remember that, as a rule, except in extreme hemorrhage and in diseases implicating the kidneys, bladder, or ureters, abdominal operations ought to be, as a rule, successful. It is well for all aspiring operators, and for many who consider themselves established, to ponder well the words of Savage. He says:

> I think we ought to get into our minds, as a prominent idea, the view that after an abdominal operation a death should be considered to

an extent as preventable, and that when one does occur we should hold with ourselves a moral inquest as to the cause, how it might have been prevented, and whether in any way it was associated with aught relating to ourselves. As time goes on, I am more persuaded that in the question of success or failure, less and less depends on the patient, her conditions and surroundings, and more and more on ourselves and the attention to certain details which have been found to be essential.

With such a standard as this a man cannot fail to do the best possible work. High ideals, though they never be quite realized, are a safeguard against the nauseating complacency with which certain operators contemplate their woeful results, blaming either Providence or the nurse, allowing themselves to escape unscathed.

It is well here to consider Mr. Savage's expression when he says, "Less and less depends upon the patient, her condition, and surroundings," for this is at once too wide, and, at the same time, widely true. It is just as evident that patients go on suffering, time and again, until they are hopelessly ill, as it is that, if taken earlier, no matter what their surroundings, they could have been cured. This fact must stand out a perpetual contradiction to those who in charity advertisements for private aggrandizement praise, in season and out, the over-laudatory achievements of hospital surgery. Right here I want to say that the best results that have ever been obtained in this city, in a wide series of cases, have been done in private houses, many of them having none of the recognized conveniences either for comfort or ideal cleanliness. The room that the patient occupied was often the only clean one in the house, and yet, as a rule, all of these patients get well. We, as operators, have no business to scare a patient into a hospital for our own convenience. By doing so we bring into the chances of her recovery an additional element of doubt.

In estimating the importance of the sequelæ of any surgical operation, we must compare them with the gravity of the condition for which the operation was done. Generally speaking, promptitude in ridding a patient of any surgical disease is a step toward avoiding after-complications as well as primary impediment to rapid satisfactory work. If a patient is suffering from suppurative abdominal disease, which by its presence threatens life primarily by septicemia, or indirectly by secondary implication of vital organs, the fact that a hernia or fistula remains after operation is no argument either against the advisability of operation nor against the results of the operation. The argument rather redounds

against the critics, and should convince them that early operation, while giving the patient a better primary chance for life, secondarily would leave him in better condition to resist the influences that tend to prevent prompt healing and, therefore, conduce to fistula and hernia formation. To appreciate these and other pathological points, a thorough appreciation of the pathology of pelvic inflammation is necessary. A devotee of the ancient doctrines of pelvic cellulitis has no hope of becoming either a skilful diagnostician in, or a surgeon of pelvic disease, since his supposed pathology does not agree with the actual condition of affairs; hence he is handicapped from the start, and the incubus of tradition must be fatal to his progress.

In advanced cases of tubal and ovarian disease, theory will tell him to treat the disease by derivative measures, aiding himself possibly by closure of a cervix, when lo! the patient grows worse in his hands, and is only rescued by the merest chance by final resort to an abdominal section. In such cases it is no uncommon experience to discover such a generally vicious condition that healthy tissue in which to place a ligature can scarcely be found, and the result is a fistula, through which a ligature ultimately is passed. Here, only the most careful technique, of making a good stump, cleaning out necrosed tissue for this purpose, and diligence in using accurately all precautions against infecting the ligature while it is being placed around the pedicle, will prevent the formation of fistula, or, at least, of the conditions that may result therein. Herniæ are cited as a perpetual menace against the propriety of abdominal operations. Women are said to be worse from them than from their original trouble. In these cases the value of personal opinion goes very little to announce the true condition. The surgeon or the critic of surgery who estimates the value of either medicine or surgery by the reports of the patient, will argue from very uncertain and worthless data. Some patients will complain more from a slight hernia than originally they did at the trouble necessitating operation, or at least their complaints are very distinct. In the first they groaned in anguish, begging relief, while at last they repudiate all surgery because they no longer suffer torture at each menstrual period. To this they are frequently encouraged by meddlesome women who, never having suffered, cannot appreciate the tortures of disease, or by malevolent professional rivals who descend to such indecent methods in order to compass the ruin or professional distrust of the community against the operator. As a

rule, herniæ, and fistulæ especially, should be rare. Hernia is a constant danger in fat women, both as primary, owing to the uncertain healing of the fat, and secondarily as a result of weakening the abdominal support. Hence, the rule should be, in all such cases, to keep the patient in bed much longer than is required to heal the incision, and, after getting up, constantly to wear an abdominal support. A failure so to advise is just as culpable as to omit the elastic support over a dislocated patella, and can only occur as the result of sheer carelessness or ignorance of the requirements of this special class of cases. Fistulæ, besides resulting from ligatures, may have their origin in lesions of the intestine resulting from the freeing of adhesions. Fecal fistulæ are rarely persistent, almost never so, and in the great majority of cases can be avoided if a careful watch is had over the bowel involved in the adhesions. Here the result of bad work must result disastrously, both so far as perpetuating the fistula is concerned and in doing damage to the intestine. To obtain perfect results the intestine is so to be mended, not only to prevent leakage of its contents, but also to avoid adhesions compromising its function and conducing to obstruction. In this relation the deaths from intestinal obstruction after operation are to be considered. In the hands of experienced operators this rarely if ever happens, and if it occurs it is recognized and relieved. One death occurring from such cause, coming under my knowledge, was the direct result of placing the patient, shortly after operation, in the care of a physician without any experience whatever in a surgical way. The complication, accordingly, was not understood, and by the time surgical aid was sought the woman was practically dead. Imperfect after-attention of surgeons eager only to operate, has been, and will continue to be, the cause of much reproach to surgery. Until his patient is out of bed and moving about freely, the surgeon has no right to dismiss her as cured. If a hernia occur after operation, it is the duty of the surgeon to explain its nature and make early effort to cure it. The earlier it is cured the less will be the obstacles in the way of permanent relief. To have a patient die of operation for hernia, the result of the surgeon's own operation, ought to be a calamity almost unheard of. Nevertheless, it ought to be understood that, owing to the size of the sac, and the consequent extent of the adhesions, some herniæ are practically incurable unless at a great risk. One such case is still fresh in my memory, in which, after a long relief, the hernia again returned. The woman was very fat, and with the difficulties of a former operation fresh in my mind I refused another.

There is no use in operating and reoperating in unfavorable cases until at last the patient is lost. Surgery nor the surgeon receives credit, while the patient receives no benefit. Imperfect knowledge of how to drain is at the bottom of many failures in the surgery of the abdomen. I once knew the question to be asked by a man following up the matters of abdominal surgery, very far off to be sure, "How long does the tube stay in—till it smells?" I have seen a tube removed containing more than an inch of coagulated serum, this last in the hands of an operator who ought to know better than now to advise the cleaning of the tube once every twelve hours, or some such long interval. A drainage-tube that needs cleaning or emptying only once in twelve hours had better be kept clean in the bag until it is wanted. Such advice as to the use of the tube is worse than worthless. To be valuable, information must come from those who are informed, not from those who are guessing or using the tube under protest or because someone else uses it. It is better not used than badly or carelessly used. Drainage and the conditions that require it must always remain a disputed question, but one fact alone must forever keep its opponents on the defensive, and that is that those who advocate it most have had the most experience with it, and that their cases so treated run a most uneventful course, even in most serious antecedent conditions. One point negativing its advantages in some cases urgently needing it, is the semi-delirious condition of the patient during the first few days immediately following operation. These patients are unruly, and their unrest will disturb the position of the tube and render it at once irritating and useless. I have two patients in mind in whom I believe the tube on this account would have been a serious disadvantage. In another in whom I considered it advisable, I removed it at once when it had become displaced. I shall never forget the anxiety with which I watched over this patient through several days, fearing the oncoming of peritonitis and dreading the possible necessity of reopening the abdomen.

But if the proper use of the drainage-tube is essential to success, it is to be remembered that crevices created by desultory breaking up of adhesions at the bottom of the pelvis, having no common outlet by which they may drain, are beyond the reach of a single tube; hence, in appendicitis for example, the careful placing of an additional rubber tube often gives security when otherwise at the best the end would be doubtful. A case of my own is here vividly before me, and brings out the theory justified by results.

When it is sought to break up adhesions on either side of the pelvis because one side seemingly presents less difficulty than the other, the more difficult should not be abandoned when once begun, unless it is plainly evident that by freeing the simpler side a vantage-point is gained from which to attack the other. Going from side to side but gives two difficulties where but one before existed, and, in event of prolonged operation, when completion for the patient's sake must be abandoned or postponed, adds additional complications and takes away some of the chances of recovery. Such methods are common to inexperienced workers, and must be abandoned if good results are desired.

Incomplete operations are at the bottom of much of the criticism made as to the uselessness of abdominal or pelvic surgery. When an operator removes but one ovary and tube for hemorrhage of a fibroid, he confesses to the knowing critic his incompetency to deal with the conditions he meets. He is as likely to cure such hemorrhage by such surgery as to raise chickens by china eggs.

By this it becomes manifest that a lack of resource is fatal to ideal surgery. The surgeon who deserves the name is a man of emergencies. The surgeon in masquerade, like the German actor, tears not his passion but his patient to tatters. By every operation so done, a certain number of women whom surgery might save are frightened and so hindered from receiving the benefits of real surgery.

The easier operations are the bane of the would-be surgeon. Succeeding in one of these, he imagines he has conquered the whole field and at once rests easy in his assurance. To such men, and their patients generally, absolute failure in their first attempts is a distinct gain, for it frightens them away from the possibility of doing further harm.

Many other points leading to and illustrating the same idea, and showing conclusively where mal-operation and needless operation is most likely to occur, and why, could be multiplied. But this is not necessary. It is plain that that operator only is safe who has first learned by a long and painstaking apprenticeship, thoroughly and patiently, the principles of the work he is to perform; who, grounding himself in the principles, has applied them at the side of capable instructors; who, when he operates, does so for the patient's good and not for his own glory. Such a man—such men—must both give their patients their best hope and be the saviours of surgery from its false exponents, who only disgrace it.

The men who get the best results are those who work along safe lines, departing from them as necessity compels according to the exigencies of each individual case; not those who from the threading of a needle to the cleansing of a tube or the washing of their hands strive to be original. Such originality hides real surgery in a multiplicity of details and paraphernalia, and risks the sufferer to exalt the operator.

DISCUSSION.

Dr. M. PRICE: I am fully in accord with the belief that most of our deaths can be accounted for by some want of care on the part of the operator before, during, or after operation. I recall two cases in which the previous care before operation had everything to do with the result. In one, the woman was sent into the house to be operated on. The patient declared that the bowels had been freely moved fifteen or sixteen times on that day. The operation was done, and it was found that the patient had not had the bowels opened for two weeks. She had an impermeable stricture, which would permit the passage of nothing but the watery contents of the bowel. The fatal result might have been avoided if the patient had been under the care of a trained nurse before the operation. I have seen this accident twice.

Many men who profess to be abdominal surgeons will go to a case of supposed tumor, or some other condition, prepared to do only that operation. They go to do an ovariotomy, and a hysterectomy is required. The result is a death. The surgeon must carry with him everything that can be needed. I have seen many hundreds of abdominal sections, and have seen about as many mistakes as most men, and that, too, in the most competent hands.

As to the success of abdominal surgery: Does anyone pretend to say that when a surgeon amputates a leg, giving the patient a useful stump, that is not a success? I hold that it is. If we had subjected an abdominal case to such a risk of life, and had left it in such a crippled condition, what a howl there would be on the part of the medical profession! You take a woman who has been lying around, unable to assist herself in the slightest, and you remove the disease and allow her to move around with some little pain, some little crippling of her gait. You cannot expect to make a perfect cure. Many of the objections, and many of what are called sequelæ, are the fault, not of the surgeon, but of the patient's delay.

Dr. G. BETTON MASSEY: The attempt has apparently been made to make an apology for surgery. I think that from some points of view the surgery of the abdominal cavity needs an apology. By some we are told that the bad results are due to improper operations, and by others that they are due to the diseases themselves. I would take no

exception to that class of bad results in those cases of abdominal disease incapable of being cured in any other way than by surgery. I have been much impressed with the mistake which is the keynote of Dr. Hoffman's paper—that is, the mistake made by surgeons of persuading women to be operated on who do not require any operation. I have seen a number of these patients who, fortunately, have failed to take the advice given by the surgeon. I have now under observation a lady who was persuaded to have her ovaries removed in order that her cervix might be repaired. A little reduction of the congestion and enlargement of the parts in a rather stout patient showed that the whole trouble came from a subinvoluted uterus and a hyperplastic enlargement of one side, which was rapidly improved.

Dr. O. H. Allis: It seems to me that a good deal depends upon who gives the advice whether an operation should be done or not. A patient comes with sarcoma of the jaw, where nothing but removal of the entire jaw, or at least half, will save life. Although the surgeon urges operation with earnestness, the patient goes away and nothing is done. The delay is fatal. The same is true in strangulated hernia. The patient should be urged to undergo immediate operation.

Dr. William E. Ashton: This question of hernia following abdominal section is one of great importance. The surgeon who says that he never has a hernia does not follow up his cases. The majority of hernias are due to a failure in properly uniting the sheath of the rectus. I do not believe that fat women are especially liable to this accident. The integrity of the abdominal wall depends entirely upon the sheath of the rectus muscle, and this should be sutured in all cases. I believe, also, that a large number of hernias are due to getting out of bed too soon. The patient should not get up under three weeks. There is not much benefit in an abdominal support. I have found it impossible to keep any bandage closely enough applied to relieve the ordinary strain. If the patient is doing heavy work, an abdominal support may be of service.

In regard to fistula caused by a ligature, I might mention a clever device told to me by a doctor from Texas. He takes a number of horse-hairs, doubles them over upon themselves and ties them together, and passes them into the fistula and turns them around. In this way he often succeeds in bringing away the ligature.

I believe it to be a good plan to have the patient in a hospital, if possible, in order that she may be under observation and control. I do not believe that there is more danger of sepsis in cases operated on at home than in those in hospitals. Sepsis does not come from the atmosphere. Barring the question of control, there is little difference, so far as results are concerned, where we operate.

Dr. J. Price: Dr. Allis has given an interesting point in reference

to the selection of cases and the importance of promptitude. The whole experience of abdominal surgeons is in favor of promptitude in pelvic abscess and in small tumors of all kinds. I may say in regard to mortality, that if my mortality equaled the number of cases that I find dead when I arrive at the house, I should cease to operate. A man to do abdominal surgery should serve an apprenticeship, not only that he may know what to recognize, but that he may, with specimens in hand, compare them with the histories. With a pair of pus tubes or a pelvic abscess, you can almost demonstrate the number of attacks of pelvic peritonitis that the woman has suffered.

It is all very nice to talk about the sequelæ of abdominal sections, but the sequelæ antedate the operation in many cases. I saw, today, a large cystoma, probably complicated with fibroid. The patient had been counseled by many not to have the tumor removed. I sometimes wish that the general practitioner and general surgeon were like the eye and ear men—they attend to their business and say nothing about anything else.

Dr. J. M. Baldy: Unquestionably many of the so-called sequelæ occur before the section has been performed. Many, also, are due to incomplete operations. I do not think that any one cause is at fault. I have not found that fistula and hernia are more apt to occur in fat women, nor have I found that suturing of the fascia will prevent it.

In regard to hospitals, I believe in railroading patients into hospitals if you have well-appointed ones. You have there a better chance to do good work and to watch the patient. Some of my best work, however, has been "alley work," but it has been most anxious work. In these cases I have been forced to permit them to get up in two weeks. In hospitals you can keep the patient in bed. I think that four weeks is not too long.

As to the cause of death, I have seen one death from shock in the hands of another gentleman. I have seen one or two deaths from hemorrhage, but the one great cause of death is septic peritonitis. In some of these cases I have thought that the tube was at fault, but in others there was no drainage. In regard to early operation, if it is an operative case, it cannot be done too soon.

Dr. Charles P. Noble: In regard to the cause of death after abdominal section, I may say that in my own experience the deaths, with two exceptions, were due to the fact that the patient was operated on when she was almost dead from disease. I have had three deaths from kidney trouble. In two the condition was not discovered prior to operation. Serious kidney disease is a positive contra-indication to abdominal section involving any considerable manipulation.

I think that our facilities for managing patients are much better in hospitals than at home, and I think that there is every inducement, both on account of the patient and ourselves, to urge her to go to a hospital.

In reference to cellulitis. Most men who do abdominal surgery say that they never see cellulitis. I have seen it but do not think that it is a common condition. I do not believe that we meet with it as a non-puerperal condition. Cellulitis in the pelvis occurs as does cellulitis in other parts of the body – from infection. I have knowledge of four abdominal operations in which the tubes were examined and found free from pus accumulation. Of course, it was not possible to say that catarrhal salpingitis was not present. Large quantities of pus, however, were evacuated through an incision over the ramus of the pubes. They were undoubted cases of pelvic abscess. I believe that this accounts for the fact that certain women recover and bear children after they have had pelvic inflammation complicating labor.

In regard to drainage: it has become my practice to drain in almost every case, and I have seen no reason to regret it. Unless there is a special reason to the contrary, I drain every case. It is often said that unless the tube is cleaned every half hour to two hours, the surgeon does not understand drainage. At the Kensington Hospital for Women, there has been a series of as many as sixty cases, with one death, where this principle of drainage was not used. In the last thirty-three cases (without a death), the drainage-tube was not evacuated oftener than three times in twenty-four hours. My experience with the capillary drain, running over one hundred cases, enables me to say that it is a most efficient form of drainage, and that it is the exception, even in bad cases, to find more than a drachm of fluid in the pelvis when the tube is drained. By this measure the pelvis is continually drained.

Dr. HOFFMAN: While a capillary drain will remove the liquid, it will not remove clots. The syringe will. All that my point stated was that cleaning the drainage-tube once in twelve hours is *not* cleaning it.

In regard to hospitals, I can control my patients better in their homes. The hospital is not a *sine qua non*, and is not free from danger.

In speaking of advice in surgery, I did not object to real advice. We, however, compromise ourselves by seeking operations, although those things are done. If an operation is necessary, we should say so, and tell why it is. If the patient does not accept it, the result does not lie at our door.

JEFFERSON COUNTY [ALABAMA] MEDICAL SOCIETY.

From the *Alabama Medical and Surgical Age*, August.

THE President, Dr. T. L. ROBERTSON, in the chair.

The Secretary being absent, Dr. W. W. RANSOM was appointed secretary *pro tempore*.

The regular essayist for the evening was not present, and Dr.

W. E. B. Davis was requested by the Society to report some of his

RECENT WORK IN ABDOMINAL SURGERY.

The following is a synopsis of his report:

Case I.—About the 1st of June he had been requested by Dr. Jolly, Superintendent of the Hospital of United Charities, to examine at the hospital, Betty B., who had been delivered of a healthy child two months previously. Since that time she had suffered continuously, and was seldom clear of fever. Her temperature would often go to 102½ degrees. There was a distinct enlargement of the ovary on the right side—the side on which she complained of so much pain—which was evidently a puerperal septic inflammatory enlargement. Vaginal tampons saturated with equal parts of glycerine and iodine were advised, and also tonics and nutritious diet; and if she did not begin to improve in two or three weeks, it was advised that the diseased tube and ovary be removed. She grew worse, and the latter part of June he was again requested to see her by Dr. Cochran, the attending physician of the hospital, and, after the patient had been anesthetized, the enlarged ovary and tube with extensive adhesions could be readily made out. The patient had already acquired the habit of taking opium and was anxious for an operation in order to be relieved of her suffering. On Friday, the 10th of July, in the presence of Drs. J. D. S. Davis, Jolly, Cochran, Perry, Wm. Luckie, and others, he made a section and found very extensive adhesions, and an ovary the size of a large walnut, and a very large occluded tube. There was but little trouble in the left ovary or tube, but the organs on both sides were removed, and the fundus of the uterus attached to the anterior wall of the abdomen. The cavity was flushed and a glass tube introduced. The operation lasted about thirty minutes, and the patient progressed as well as could be expected in a morphine case. There was a mural abscess which gave but little trouble. She is now sitting up, and does not take morphine—does not even want it. It may be of interest to say that her temperature went up twice to 104 degrees, merely from nervous excitement. It only remained up a very short while each time.

Case II.—Elsie B., aged 27; colored. This woman had been operated on four months previously, and a cyst of the right ovary removed. After she had gotten up from the operation, there began to develop a hard tumor above the umbilicus, with a temperature of 102 degrees in the afternoon. She had but little appetite and did not digest what she ate. She did not improve, but continued to grow worse, as the tumor grew large. It was explained to her husband that this was most probably a malignant growth, but that it might be an abscess. If the latter, there was hope of relieving her by an operation, but if malignant, the operation could not benefit her. She was advised to go into the hospital for an exploratory incision, which she did, and the operation

was done on Friday, July 1st, in the presence of Drs. J. D. S. Davis, and Wm. Luckie, and Mr. Williams, and others. The incision was just long enough to explore with two fingers, and there was no difficulty in making out a cancer of the mesentery. The operation lasted only twelve and a half minutes, and the patient never seemed to have any symptoms from it. The incision has healed perfectly without pus, but the patient is gradually dying from the cancer.

Case III. – On the same day that he operated on Case II. he was called to Pratt Mines by Drs. Brown and Cunningham to see J. Kellar, aged 19 years, who had been shot with a 42-calibre pistol at 11 o'clock the night before. The ball entered one and a half inches from the spinal column, and just below the last rib on the left side. A probe would enter the cavity through the opening. There was blood in the urine, and the abdomen was very rigid, giving evidence of a general peritonitis. His temperature was 100½ degrees and pulse 100. It was decided to have him brought to the hospital in Birmingham, a distance of five miles, to be operated on. At 3.30 P. M., seventeen and a half hours after the injury, an exploratory section was made in the presence of Drs. Geo. Brown, Cunningham, J. D. S. Davis and others. The incision was four inches long, external to the left rectus muscle, with its center a little above the umbilicus. The abdomen contained a large quantity of dark, dirty-looking blood, and there was present a diffused peritonitis. The ball had passed through the kidney and spleen, but had not injured the intestine. It was removed from the internal anterior wall of the abdomen, where it was lodged, which was on a direct line with the wound of entrance. After washing out the cavity thoroughly and replacing the intestines, which was done with some difficulty, owing to distension—all bleeding being stopped—the incision was closed and a glass drainage-tube placed in the lower angle of the wound. The operation lasted thirty-five minutes, and the patient did not suffer shock. He lived forty hours, and died from the general septic peritonitis, which existed at the time of the operation. It was impossible to get the bowels to act, owing to the extreme paralysis from the inflammation. The peritonitis was evidently caused by the urine in the blood, which escaped from the kidney, and proves the necessity of prompt operative procedure, not only in cases where the bowel is perforated, but also in kidney injuries, in order to keep the patient from dying from peritonitis. The man could not have been saved by any procedure at the time he was operated on. Just here it should be stated that it would have been better to incise the gut in this case, so that the gas could have escaped, and allowed the bowel to be replaced with less traumatism. The wound of entrance was opened by a free incision and drained.

Case IV.—On Thursday, July 16th, he removed the ovaries and tubes from Mrs. Ella D., aged twenty-eight, at the hospital, in the

presence of Drs. J. D. S. Davis, Chas. Hickman, William Luckie, and others. She had been treated for uterine hemorrhage by the curette electricity, Emmet's operation on the cervix, etc., but without permanent benefit, and the bleeding continued to grow worse, and she continued to lose flesh. There was considerable pain in both ovarian regions, with all the symptoms of salpingitis. The operation lasted eighteen minutes, and the patient recovered without an unfavorable symptom. She is now able to sit up in bed.

Case V.—On the same day that he operated on Case IV., he received a telegram to go to Columbiana "prepared to do laparatomy," and found Mrs. L., aged fifty years, with an umbilical hernia as large as a child's head, which had been strangulated for fifty hours. Her pulse was 130, and feeble. It was decided to give her the benefit of an operation, notwithstanding her extreme condition, Davis's catgut mats and Senn's bone plates were placed in readiness, so that they might be used if the bowel had been destroyed by the strangulation, provided the patient's condition would permit of it. After the incision was made, which was quite free, the bowel was found extensively attached, and there were already two large holes in the intestine, which could not be remedied except by resection and anastomosis. The patient was very feeble, and there was nothing to be done except to make an artificial anus. It was apparent as soon as the sphacelated condition of the bowel was seen, that the operation had been done too late, for the patient's condition was so extreme that she could scarcely have been expected to recover after an operation for the relief of a simple strangulation.

Case VI.—Mrs. M. A. L. had been seen in consultation with Drs. Finch and Barrett, of East Lake. She was thirty years of age, and for two years had suffered with extreme procidentia. She had not been able to keep the uterus in the vagina for some years—not since the birth of her only child, a boy of eight years of age. For several months she had been suffering extreme pain in both ovarian regions, and had been confined to the bed a great deal, and has recently had to take opium constantly. The body of the uterus was bound down, and while the canal measured six inches, it was not prudent to attempt an operation on the cervix. The elongation of the neck was above the vaginal insertion. She was advised to enter the hospital for operation, which she readily assented to; and on Monday, July 20th, she was operated on in the presence of Drs. Finch and Barrett and C. C. Jones, of East Lake, Dr. Jones, of Woodlawn, Drs. J. D. S. Davis, William Luckie, and others. After the incision was made, there was found the most extensive adhesion he had ever seen. Bowels and everything were attached. It was very difficult to make out anything. A hematosalpinx of large size was found on the right side, and an ovarian cyst,

as large as a small orange, on the left side. After their thorough removal, the uterus was brought up and attached to the abdominal wall by the two lower stitches, which passed through one side of abdominal wound, then through the wall of fundus, and then through the other side of the abdominal wall. When these two ligatures were tied, they closed the lower angle snugly and brought the uterus up against the abdominal wall. The abdomen was flushed with hot water, and a glass drainage tube put in, which was removed in twenty-four hours. This case did not do well for a while, a large abscess having developed in the abdominal wound. She had a very rapid pulse for three days. Since that time she has been doing well, and now, eight days after the operation, says she feels well enough to be out of bed.

Case VII. — This is a case in which suprapubic cystotomy was done for the removal of a stone. The patient, a boy eight years of age, was sent to him by Dr. Cotton, of Ensley, and was operated on in the hospital, Saturday, July 25th. He has had no unfavorable symptoms since the operation, which lasted twelve minutes. He thinks the high operation preferable in all conditions requiring the bladder to be opened.

After the discussion of these cases, Dr. J. D. S. Davis presented a perforated appendix removed after death from a boy upon whom he had performed two sections for the removal of pus from the abdomen. Dr. Davis first saw the boy, aged twelve years, February 1, 1891. He had been treated by Dr. Cooper for fever, accompanied with occasional attacks of dysentery, when he discovered an enlargement on the right side, extending from the right iliac region to the border of the ribs. When Dr. Davis first saw the patient, his pulse was 120 per minute and temperature 102°. He had frequent actions accompanied with bloody discharges. An immediate operation was advised, but was unavoidably postponed. Fifteen hours later the patient was anesthetized and abdomen opened, by an oblique incision three inches in length, beginning above the spine of the right ilium. The abdomen was found to contain pus from a recently ruptured abscess, and two abscess sacs unruptured. The abscesses were broken up and contents removed, which was about a pint of very offensive pus. The abdominal and abscess cavities were drained by a double rubber and glass drainage-tubes. The abdominal incision was closed by including the peritoneum in the sutures. The drainage tubes were kept dry by a long-nozzled rubber piston syringe. The temperature the first day after the operation was 100°; pulse, 100; second day, temperature 98½°; pulse, 105; third day, temperature 99°; pulse, 105; fourth day, temperature 98¼°; pulse, 105. After the sixth day the temperature remained

normal, pulse gradually getting stronger. On the third day the glass drainage-tube was removed ; the stitches on the sixth ; the rubber tube was accidentally displaced and opening completely closed on the ninth day. The patient made a rapid and uninterrupted recovery, and was on the street on the eighteenth day. He enjoyed perfect health until July 8th, when he was seized, while playing ball, with a sharp pain in the abdomen. A half-teaspoonful of paregoric was administered, and Dr. Whelan was summoned. He found the patient easier, with a slight fever and excited pulse. After learning a complete history of the case, he advised an immediate exploratory incision. The mother refused. He was then placed on Epsom salts and the bowels freely purged. Dr. Davis saw the case in consultation July 10th, when all the symptoms were very much relieved ; temperature reduced to 100°; pulse, 95; and swelling subdued. Under the favorable improvement, operation was postponed on the ground that if he had suppurative peritonitis the operation at so late a time could not be expected to save him ; and, on the other hand, if there existed no rupture or perforation, but simple peritonitis (non-suppurative), the salts so far had met every indication. Dr. Whelan saw the patient every five hours, and on the following day Drs. J. D. S. Davis, W. E. B. Davis and T. L. Robertson were in consultation. Temperature then was 103°; pulse, 125 ; brow contracted and facial expression anxious. An immediate laparatomy was decided upon, with little hope of recovery. An incision was made in the right iliac region over the appendix, and a large quantity of offensive pus removed. An unsuccessful, hurried search was made for the appendix, the cavity well irrigated, a glass drainage-tube inserted and the incision closed. The patient died forty hours after the operation. The necropsy revealed numerous adhesions, perforated appendix buried beneath the cecum and surrounded by a ruptured tumor wall. The walls of the appendix were very thick and indurated. A radical operation had been advised in this case after recovery from the first.

Birmingham, July 28, 1891.

BUFFALO MEDICAL AND SURGICAL ASSOCIATION.

Reported by W. S. RENNER, M. D., Secretary.

Regular meeting held Tuesday, July 7, 1891, in the parlors of the Hotel Iroquois.

Dr. Edward Clark in the chair. Dr. A. L. Benedict read a paper on the Treatment of Chronic Dyspepsia, and Dr. Albert E. Persons read a paper on Disorders of Nutrition.

DISCUSSION OF BOTH PAPERS.

Dr. HAYD said that it was not surprising that we had so much dyspepsia in this country, owing to our habits of life. Washing out the stomach had proven a great aid in the diagnosis and treatment of diseases of the stomach, in fact it is the only treatment in chronic dyspepsia; it carries away all irritating substances, stimulates the muscular walls, and, perhaps, even regenerates some of the tubules. He related the history of a case: A woman weighing eighty-six pounds, with dyspepsia, but no organic disease of stomach, (in this case he found traces of hydrochloric acid in the contents of the stomach,) had increased in weight under this treatment until now she weighs 186 pounds. He does not believe that medicines are of any use in these cases. You must first remove the fermentary elements. He has used both the faradic and galvanic currents in dilatation of the stomach, with good results. He believed that the belching and acidity, in many cases, is not due to stomach disease, *per se*, but is of reflex origin.

Dr. HARTWIG said that it was necessary to examine into the habits of the patient for the cause of indigestion in many cases. To get contents of the stomach for examination, he is in the habit of letting the patient swallow a small piece of sponge attached to a string and enclosed in a capsule. The sponge is drawn out after the capsule has dissolved. The contents are then squeezed out of the sponge and examined for hydrochloric acid.

Dr. BARTLETT had found the test for hydrochloric acid of value in diagnosticating a case as one of ulcer, and not cancer, of the stomach.

Dr. E. H. LONG thought the term dyspepsia should be dispensed with, and *indigestion* used instead, except when the gastric disturbance is due to disease of some other organ; in which case the cause should be stated.

Dr. CLARK thought that physicians "drug" their patients too much for stomach troubles. Much trouble was due, in children, to the formation of tyrotoxicon in the milk. In some cases milk is an absolute poison to children.

Dr. HAYD reported a case of paresis of syphilitic origin, greatly benefited by very large doses of iodide of potash. The patient is now under the care of Dr. Loomis, of New York, who is giving her 480 grains of iodide daily.

Dr. HARTWIG reported a case of syphilitic laryngitis.

Meeting adjourned at 10.30 P. M.

THE MEDICAL SOCIETY OF CHAUTAUQUA COUNTY.

The annual meeting of the Chautauqua County Medical Society was held at the Hotel Chautauqua, Mayville, July 14th. It was an unusually interesting meeting, as regards business coming before the Society, the large number in attendance, and the character of the papers read.

Three years ago, after an earnest discussion over the question of retaining affiliation with the State Medical Society, the affirmative was carried. For some unaccountable reason the delegate fees had not been forwarded and the Society found itself seven years in arrears of dues.

The question was again brought forward and, after some interesting discussion, the newly-elected treasurer was instructed to forward the unpaid dues. The vote was unanimous.

The Society had as its guest Dr. William Warren Potter, of Buffalo, ex-President of the State Medical Society.

The following papers were read: Pelvic Inflammation in Women; a Pathological study, by Dr. William Warren Potter, Buffalo, N. Y.; Iritis and Glaucoma, by Dr. Geo. E. Blackham, Dunkirk, N. Y.; The Last State Medical Society, by Dr. Nelson G. Richmond, Fredonia., N. Y.; Fracture Bed, by Dr. C. A. Ellis, Sherman, N. Y.; Removal of a Large Uterine Fibroma, with Specimen and Clinical Notes of Convalescence, by Dr. Laban Hazeltine, Jamestown, N. Y.

Officers were elected as follows: President, Dr. A. Waterhouse, Jamestown; Vice-President, Dr. Nelson G. Richmond, Fredonia; Secretary and Treasurer, Dr. A. H. Bowers, Jamestown.

A Crematory in Troy. — The new crematory to be erected in Oakwood Cemetery, Troy, the gift of Mr. Wm. S. Earl, will probably cost $150,000. It is to be of granite, 136 feet long and seventy feet wide, and will be a mortuary chapel and retort.

The Prevention of Phthisis. — A French writer observes that the prophylaxis of tuberculosis may be summed up in five words: "Keep water in the spittoon."— *St. Louis Medical and Surgical Journal.*

Progress in Medical Science.

PHYSIOLOGICAL CHEMISTRY.

CONDUCTED BY

JOHN A. MILLER, Ph. D. (BERLIN).

THE GERMICIDAL ACTION OF EGG ALBUMIN.

A. WURTZ (*Compt. Rend. Soc. Biolog.*, 42, 20; *Ber. Deut. Chem. Ges.*, 24, 465,) found that by the digestion with the uncooked white of egg at 38° a small number of bacillus anthrax, cholera-spirillum, Ebert's bacillus, bacillus pyrogenes aureus, and of bacillus subtilis were killed. This property of the albumin prevents the invasion of eggs by bacteria. Coagulated egg albumin has no germicidal properties.

INFLUENCE OF ALKALIES ON THE FORMATION OF GLYCOGEN IN THE LIVER.

E. DEFOURT (*Compt. Rend. Soc. Biolog.*, 42, 146; *Ber. Deut. Chem. Ges.*, 24, 466,) finds that after the administration of sodium bicarbonate to dogs and guinea-pigs, the total contents of sugar in the liver was in excess of the normal.

OXYGEN IN THE BLOOD OF ANIMALS AT GREAT ALTITUDES.

VIAULT (*Compt. Rend.*, 112, 295; *Jour. Chem. Soc.*, 60, 753,) finds that at great altitudes the proportion of oxygen in the blood of animals is practically the same as at low levels. It would seem that the greater rarefaction of the oxygen is compensated by the greater degree of subdivision of the red corpuscles and their consequent greater absorptive activity.

EFFECT OF MEDICINES, AND ESPECIALLY OF VALERIAN EXTRACT, ON THE DESTRUCTION OF DEXTROSE IN THE BLOOD.

L. BUTTE (*Compt. Rend.*, 112, 347; *Jour. Chem. Soc.*, 60, 754). Sodium bicarbonate and morphine retards the destruction of dextrose in the blood, but curarine accelerates it. Valerian extract retards the destruction very considerably when added to freshly

drawn blood, and also when injected into the left femoral vein of a dog.

ISOLATION OF THE GLYCOLITIC FERMENT OF THE BLOOD.

R. Lepine and Barral (*Compt. Rend.*, 112, 411; *Jour. Chem. Soc.*, 60, 755). Fresh dog's blood was defibrinated and placed in a powerful centrifugal machine; the serum thus separated was found to have very little glycolitic power. The separated corpuscles were treated with a volume of salt water equal to the original serum, and the process of separation repeated; the salt solution contained less albumin than the serum, but its glycolitic power was much greater. A second treatment with salt water gave a liquid with very little albumin, but with still greater glycolitic power. It follows, therefore, that the destruction of glucose is not due, as Arnaud has supposed, to some action of living blood albumin; the results point, in fact, to the existence of a soluble ferment.

PATHOLOGY OF PROTEIDS.

S. Martin (*Brit. Med. Jour.*, 1, 1891; *Jour. Chem. Soc.*, 60, 761). The changes in structure that occur in a diseased tissue or organ are associated with chemical changes, and it is to certain changes in the proteids, the most abundant constituent of most living structures, that attention was chiefly directed in the present research; although peptones and albumoses are found in the alimentary canal, their presence elsewhere in the body is pathological, as during normal absorption they are regenerated into the blood proteids. The action of microörganisms during putrefaction is, first, similar to that of pepsin, namely: it forms albumoses and peptones, but, subsequently, ptomaines may make their appearance. Putrefaction (using the word in the wide sense of the changes due to microbes) is, moreover, a frequent factor in pathological processes, and albumoses and peptones are poisonous substances. If these poisons are found in decomposing collections of cells, as in abscesses, empyema, phthisis, etc., they pass into the lymph and blood-streams, passing ultimately from the body by the urine, constituting what is generally termed peptonuria, but which should be more properly called albumosuria, the proteid which is present being deutero-albumose. Illustrative cases are cited which show the amount of albumose in the pus and in the urine before and after the evacuation of the

abscess, the albumose in the urine varying with the amount of accumulated pus.

One of the most striking features of pus-formation which is common to it and albumose poisoning is fever. It is possible that other factors have also to be considered: thus leucine, often found in pus, is a fever producer: alkaloids, if they do exist, have yet to be isolated.

In ordinary pus, the agent which forms the albumoses is probably not an euzyme, but the *staphylococcus pyogenes aureus*; in tubercle, it may be the tubercle bacillus.

But the presence of albumoses in disease cannot always be ascribed to microörganisms, as in glycosuria and osteomalacia. In osteomalacia the diseased bones contain an albumose similar to that excreted in the urine, and, perhaps, due to the rapid breaking down of lowly organized cells. In the puerperal state, the origin of the albumose may be the degenerating cells of the hypertrophied uterus which is undergoing involution. The origin of albumoses in other cases, such as measles, is at present involved in obscurity.

CULTIVATION PRODUCTS OF THE TUBERCLE BACILLUS.

E. M. Crookshank and E. F. Herronn (*Brit. Med. Jour.*, 1, 1891; *Jour. Chem. Soc.*, 60, 762). In cultivations of the tubercle bacillus in glycerol broth, albumoses, substances of the nature of albumose and peptone were identified, and also a substance which gives the reactions of an alkaloid. The latter was, however, obtained in too small a quantity for more than a qualitative analysis. Injected into animals, symptoms similar to those produced by Koch's tuberculin were obtained.

MEDICO-LEGAL NOTES.

By HENRY A. RILEY, Esq., New York

INCREASE OF CRIME AND THE DEATH PENALTY.

A recent writer in the *Judicial Review*, says that murder has increased to an alarming degree in those countries where the death penalty has been abolished. In France, from 1828 to 1884, murders increased from 197 to 234 a year; infanticide, from 102 to 194; blows and assaults, from 8,000 to 19,000; robberies, from 9,000 to 33,000; and that in 1885 crime was still increasing.

In Belgium, murders increased in a frightful manner whenever the knowledge of the abolition of the scaffold spread among the masses. In Prussia, where for many years there had been no executions, murders increased from 242 in 1854, to 518 in 1880. In Switzerland, where capital punishment was abolished in 1874, murders increased in five years in the proportion of seventy-five per cent.

This startling increase is in some slight degree explained by the fact of the considerable increase in the population of these countries; still, it is difficult to account for the remarkable change, except on the theory of the deterring effect on criminals of the death penalty.

In this country most of the States inflict the death penalty, but in some of them there is a practical abolition of executions, even when the law authorizes them. In Kansas, for instance, the statute says that the Governor "may" fix a day for execution, and the result is that there has been no execution for years, while the prisons are full of convicted and sentenced murderers. The Governors say that if the Legislature wishes to have the death penalty inflicted, it can easily change the word "may" to "shall," and in such case they would promptly issue the warrants.

In New York, the attorneys for convicted murderers have discovered a way of indefinitely prolonging their lives by appealing from the State courts to the Federal tribunals. It seems possible to take such appeals on frivolous and purely technical grounds, and the crowded calendars of the Federal courts prevent their consideration and decision for long periods.

MUST PHYSICIANS ANSWER CALLS?

According to a newspaper report, a New Haven physician was fined not long since $10, because he did not answer a call in an urgent case. It is very doubtful if such a case actually occurred, as it seems quite clear that there is no legal liability on the part of physicians to give their services to every one who may call for them. If it were so, the lives of some popular and trustworthy physicians would be a burden too great to be borne.

The principle of the common carrier in law, which requires railroad companies to accept and transport all passengers and freight offered them at regular rates, does not have any application to physicians so as to force them to give their services to all comers.

It is just that railroads should be under such a duty, as they are public corporations and receive valuable franchises from the State for which every citizen has a right to demand an equivalent.

Perhaps the point has never been directly decided by a court of high jurisdiction, but in a recent New York case where a physician was charged with malpractice, one of the defenses was that he was treating the patient gratuitously. The judge, in charging the jury, used this language:

He may decline to respond to the patient unable to compensate him, but if he undertakes the treatment of such a patient he cannot defeat a suit for malpractice, nor mitigate a recovery against him upon the principle that the skill and care required of a physician are proportioned to his expectation of pecuniary recompense.

This is practically a decision of the point.

ARE PUGILISTS ARTISTS?

The recent pugilistic encounter in which an Australian, named Slavin, was victorious, has had the curious result of drawing attention to a violation of the Contract Labor law. It is now claimed that the bargain made by Slavin and Mitchell to exhibit themselves in pugilistic encounters through the country was a violation of the law, which only allows "artists" to be exempt from its provisions.

A letter from an individual who resented their coming to this country on such a brutal errand, when a person is prohibited from bringing a servant into this country, was the means of calling the attention of the Commissioners of Immigration to the matter. The men have now both returned to England, so that nothing can be done to them for breaking the law, but the speculator in pounding, who brought them here and then failed to carry out his agreement, is liable to a heavy fine. He can only escape if the matter is pressed by proving that pugilists are "artists," and an effort to do this will be watched with interest. It may occur to him that as barbers and other like individuals are occasionally styled "professors," it is no great stretch of the imagination to conceive of the representative of the "fistic art" as an artist. One result of the matter will probably be, that native pugilists will be to some measure protected against the competition of foreign sluggers, and that our own citizens will have most of the honor, glory and money of the prize ring.

AN INFANT CRIMINAL.

The Omaha *World-Herald*, of a recent date, has this interesting editorial item: "There is a certain way to make criminals, just as there is a certain way to make houses or clothes, or anything else you are minded to mention.

"One of the best and quickest ways to make a criminal, is to charge a baby of seven years with grand larceny, and lock her up in the police station. Tillie Schuster is said to have stolen $50. Perhaps she did; but if she did, she did not know the difference in value between that and fifty cents. Ask any child of seven whether he would rather have one dime or nine pennies, and if he sees them in your hand he will choose the nine pennies.

"If Mr. Wicksworth thinks Tillie Schuster stole his money, there are other ways of getting it back or finding out where she has put it or how she has destroyed it, than by arresting her and putting her in with criminals. That was a crime worse than larceny."

A SUIT BY SIR MORELL MACKENZIE.

Sir Morell Mackenzie has just brought suit for $10,000 damages against the Sodene Mineral Spring Co., claiming that his name was used without authority in the advertisements printed by the company. A temporary injunction has been granted, and the trial will be held after a time. Sir Morell charges the defendants with treading upon his professional reputation.

OPHTHALMOLOGY.

By ALVIN A. HUBBELL, M. D.

INFLUENZA AS A CAUSE OF OPTIC NEURITIS.

Macnamara, of London, in a recent address, (*British Medical Journal*, August 1, 1891,) alludes to neuritis of the optic nerve occurring in conjunction with influenza, and as appearing analogous to cases which he has described as "malarial peripheral neuritis." He refers to four cases, three male patients and one female, suffering from double optic neuritis, which came on while they were passing through an attack of influenza. In these cases the patients' sight had been perfectly good until they were seized with influenza, and there was no evidence of any intracranial affection, albuminuria, or any other cause with which could be associated the affection of

the optic papilla from which they suffered. In the first case that came under observation, the patient had been absolutely blind for six weeks before he saw him. There was intense papillitis with numerous retinal hemorrhages. Both optic discs became atrophied and the patients did not regain the slightest perception of light. The other cases were recent and showed uncomplicated papillitis with great impairment of vision. The discs in all three cases gradually cleared up, mercurial treatment being used, and the patients regained perfect vision. He suggests that the neuritis depends "upon either direct local irritation produced by microbes on the optic nerve, or on the ptomaines secreted by these micro-organisms."

Dr. Weeks, of New York, (*New York Medical Journal*, August 8, 1891,) has also written an interesting paper on forms of optic neuritis, caused by *la grippe* or influenza. He reviews cases published by others, and cites one case of his own. In all, he collects fifteen cases. Of these, "nine occurred in females and six in males, at ages ranging from eighteen to fifty-eight years. There was an inflammatory condition of the disc in four cases; paling of the disc, more or less marked, in eleven cases; one eye was affected in four cases, both eyes in eleven. Blindness (permanent) resulted in one eye in one case; perception of light in two eyes in two cases. Approximately, complete recovery occurred in one case only. The scotomata produced were very varied, affecting all parts of the visual fields. Central scotoma without appreciable limitation of the visual fields occurred in two cases. The scotomata were for *all colors* except in one case." Weeks draws the following conclusions:

1. Neuritis of the optic nerve due to *la grippe* is of relatively rare occurrence; it may affect one or both eyes, and may produce partial transient impairment of vision, partial permanent impairment of vision, or absolute permanent blindness.

2. Failure of vision begins from three to fourteen days after the commencement of the attack of *la grippe*, and proceeds quite rapidly. It is always preceded by intense frontal or circumorbital cephalalgia.

3. The form of scotoma produced is probably dependent on the position of the neuritis in the course of the nerve from the globe to the chiasm. If immediately behind the globe, the macular fibres are affected; if near the optic foramen, the peripheral fibres suffer first.

4. Treatment has but little effect to promote cure. If recovery follows, it takes place spontaneously and accompanies improvement in the patients' general condition.

MEDICINE.

BY

WM. C. KRAUSS, M. D.

In the *Bulletin Général de Thérapeutique* for April 18, 1891, Dr. August Voisin, of Paris, gives his experience with chlorhydrate of morphia in mental and nervous disorders.

Indications.— The indications for the treatment of mental alienation apply, above all, to those forms of simple disease, or those freed from congestive complications. It is very useful in hallucinations, in the depressive state, in all forms of alcoholism, suicidal or homicidal motives, etc. In hysterical mania, the author has had excellent results, also in puerperal mania.

It is contra-indicated in all inflammatory forms of mental disease, such as following epilepsy and certain forms of general paresis. It may even be detrimental in cases where the alienation is consecutive to atheromatous changes in the arterial system. The dose is six centigrammes, and more, daily.

NEW REMEDIES AGAINST TUBERCULOSIS.

Since the publication of Koch's treatment of tuberculosis, scores of experimenters have put in claims, believing that the real specific has at last been found in his particular remedy. Not to mention the Gibbes-Shurly and Liebrich treatments, we find in recent literature such remedies as goat blood injections, hypodermic injection of oil of creosote, oil of guaiacol, thymolo-acetate of mercury, along with the internal administration of iodide of potassium, inhalation of chloroform and ether, etc., etc. The life of the tubercle bacillus can only be destroyed by carefully studying its biological relations, and we believe, therefore, that the Koch plan is one which will eventually succeed.

Killsbren, in an article on Chloralamid, in the *Memphis Medical Monthly*, makes a comparison between chloralamid and

chloral on one hand, and sulfonal on the other. His results are as follows:

Compared with chloral:

1. It is more agreeable to the taste, and consequently easier administered.
2. Rarely causes digestive disorders.
3. Does not depress the heart or circulation.
4. Seldom produces cerebral disturbances.

As compared with sulfonal:

1. Much more prompt in its action.
2. Being more soluble, it can be administered easier.
3. Sleep nearly always passes away by morning.
4. It is only about one-half as expensive.

THE PATHOLOGICAL ANATOMY OF TIC DOULOUREUX.

In *The Journal of Nervous and Mental Disease*, Vol. XVI., p. 54, Dr. C. L. Dana, of New York, asserts that trigeminus neuralgias are not due to neuritic or degenerative processes, but to an arterio-sclerosis, which limits the supply of blood to the nerve. In four cases in which he excised a portion of the trigeminus, no organic process in the nerve could be demonstrated. In three of these, however, sclerotic patches were present in the vessels. Therapeutically he recommends agents which act on the vaso-motor system, such as aconitin, nitro-glycerin, etc.

Selections.

SOMNAL—A HYPNOTIC.

By IRVING D. WILTROUT, M. D.,

Physician in charge of the Holmes Sanitarium for Nervous Diseases, Hudson, Wis.

Since I have been placed on the Committee on New Remedies, and in view of the fact that I am always desirous to keep up the interest of this Society by promptly responding to any task that may be set before me, I write this brief paper on a remedy that is not new to all of you, but some of you may not yet have tested its merits in that most annoying and often intractable symptom—insomnia.

The remedy I refer to is somnal. I show you here a sample of

it. It is, as you see, a colorless liquid, resembling chloroform in its appearance and behavior when added to cold water, in which it forms globules, and refuses to mix or dissolve. When shaken with water the mixture is milky, but quickly separates. It is soluble in hot water and alcoholic solutions, and dissolves resinous substances and fats. The odor is rather delightful, and resembles somewhat that of spirits of nitrous ether. The taste is pungent, and for administration it needs free dilution. When whisky is not objectionable, or alcohol, it can be dissolved in either, to which water can then be added until the taste is not unpleasant. The taste can be disguised well in syrup of ginger or licorice.

Somnal is inflammable, and burns with a flame resembling alcohol. Somnal can be said to be a new remedy, for it was first brought to notice by Radlauer, of Berlin, in the Fall of 1889. It is formed by the union of chloral, alcohol, and urethrane; but it is not simply a mixture of these bodies. It differs from chloral-urethrane by the addition of C_2H_4, its formula being $C_7H_{12}Cl_3O_3N$. The dose ranges from fifteen to thirty drops. In its action it resembles chloral in quickness of effect and naturalness of the sleep produced. No marked depressing influence is exerted upon the pulse or respiration, though it is noticed that the breathing becomes slower and the pulse slower and fuller, as in natural sleep.

I have used this drug in upwards of thirty cases, and in no instance did I find any disagreeable after-effects. The head remains clear on waking, and the stomach unaffected. No constipating or relaxing effect follows its issue. The kidneys are slightly quickened. No increase of dose is called for, however long you use the remedy. Usually two doses are sufficient. I have the habit of giving the first dose at eight o'clock and the second at ten. A night's rest usually follows. In aggravated cases of insomnia I order a third dose administered at two A. M. if the patient is wakeful.

The sleep is very natural. It does not, like chloral, depress the heart, irritate the stomach and produce morning drowsiness, or disturb the gait, dull the sensibilities and irritate the stomach, which is often the case when sulfonal is used. In a form of insomnia which accompanies general neuralgic pains, this remedy almost invariably relieves the pain, and provokes a restful sleep.

In the fretfulness of nervous people who cannot sleep, as in cases of melancholia agitata, hysteria, hypochondria, and puerperal mania, I have found this remedy preferable to any other.

I have no experience in using this drug in the sleeplessness of children, nor have I witnessed its results in the acute febrile diseases. I believe that this remedy stimulates the gastric mucous membrane, and by so doing of tenrelieves nausea and pain, improves the appetite, and regulates the bowels.

Its power of relieving nausea and accumulation of gas in the stomach is very pronounced. I have in three instances administered it in small doses during the day for this purpose. The results were exceedingly satisfactory. As it is rapidly eliminated from the body, it may be administered each night or a number of days without any possibility of ill effects.

I am fond of old remedies; I take up new ones cautiously, but in my efforts to give refreshing and restful sleep to the sleepless and worn-out nervous cases that come under my care, I was ready to put this new remedy into immediate use, and I have done so with the results given above.—*N. W. Lancet.*

THERE is more than one leper to every 5,000 of the population in the vale of Kashmir. The entire number of inhabitants is only half a million.

AT THE WRONG BUSINESS.—Physician: "What is your profession, sir?" Patient (pompously): "I am a gentleman." Physician: "Well, you'll have to try something else; it does'nt agree with you."—*Life.*

ELECTROCUTION is the word coined to express legal death by electricity. Science, so-called, has invaded every domain, and now comes in to take the shame out of the legal death penalty. Is it science, though? and does not this innovation defeat the intent of criminal death punishment?—*N. C. Medical Journal.*

EDEMA OF THE GLOTTIS FOLLOWING INFLUENZA.—Before the Imperial Society of Medicine at Constantinople, Bavachi (*Gazette Med. d' Orient*, April 15, 1891,) reported three cases of influenza in which edema of the glottis developed. One was in a man of fifty, the second in a man of thirty, and the third in a girl of three. The first died, the general condition not being favorable for tracheotomy; the other two recovered without operative interference.

BUFFALO MEDICAL AND SURGICAL JOURNAL

A MONTHLY REVIEW OF MEDICINE AND SURGERY.

EDITORS:

THOMAS LOTHROP, M. D. - - WM. WARREN POTTER, M. D.

All communications, whether of a literary or business character, should be addressed to the managing editor: 284 FRANKLIN STREET, BUFFALO, N. Y.

VOL. XXXI. SEPTEMBER, 1891. No. 2.

KOCH VS. VIRCHOW.

WE NOTICE, just at present, in many of our exchanges, a vein of jest, if not abuse, directed against the greatest of modern experimenters — Professor Koch, of Berlin. Ever since the publication of Virchow's manifesto, denouncing everything connected with the "lymph" question, the tirade of abuse began. Perhaps it will be well to bear in mind that Prof. Virchow was equally as denunciatory of Prof. Koch and his methods in 1882, when the latter, through his wonderful discovery of the bacillus, let the bottom fall out of Virchow's pet tuberculosis theory. Time has proven who was right, and we have no doubt but that in ten years from now, time will again demonstrate that all advancements do not emanate from Prof. Virchow.

In a recent debate in the lower house of the Prussian Diet, Prof. Virchow denounced Kochism as a failure, and opposed with all his power (?) the granting of 165,000 marks for Prof. Koch's Institute. Happily, Prof. Virchow is not as successful in politics as in science, and the honor of German medicine was sustained. We do not propose to belittle the magnitude and influence of Virchow's achievements, but when we see him at his old tricks, and this time transferring a scientific question into the political arena, we think he had better be in other business.

We still hold to the belief that Prof. Koch is on the right trail, and judging the man by his past efforts, we will be sadly mistaken if his experiments are not crowned with success. It requires time to work out such problems as "the cure of tuberculosis," but when pluck, brains and modesty are all combined in one head, we need

not fear the result. Professor Koch deserves as much honor and appreciation now as he did before his adversaries took him to task on a point which was unwillingly wrenched from him.

W. C. K.

IMPORTANT TO MEDICAL STUDENTS.

The Cleveland *Medical Gazette* for August, 1891, publishes some good advice under the above title, which we cordially endorse and cheerfully reproduce:

"Several medical colleges are advertising to graduate students at the end of the coming Winter term upon the attendance of *two courses of lectures*. Medical students should be informed that graduates of such schools will not be entitled to practice medicine in more than half the States of the Union, representing over forty millions inhabitants.

"The State Examining Boards throughout the country have given sufficient notice of what would be required of medical colleges, and all reputable schools have adopted the three-year graded course of study; but several so-called medical colleges throughout the country thinking to profit by the increased time of study required by most medical schools, are soliciting patronage by offering to graduate *one more* class at the end of the second course of lectures. We believe it to be the duty of the medical journals to warn students against all such institutions and decline to insert advertisements of these schools. This will be our policy. We had hoped to publish a list of all schools not coming up to the requirements of the various State Boards of Health, but have failed to secure the complete list for this number of the *Gazette*."

Membership in the American Medical Association.—This is obtainable, at any time, by a member of any State or local medical society which is entitled to send delegates to the Association. All that is necessary is for the applicant to write to the Treasurer of the Association, Dr. Richard J. Dunglison, Lock Box 1274, Philadelphia, Pa., sending him a certificate or statement that he is in good standing in his own society, signed by the president and secretary of said society, with five dollars for annual dues. Attendance as a delegate at an annual meeting of the Association is not necessary in order to obtain membership. On receipt of the above amount the weekly journal of the Association will be forwarded regularly.

CORRECTION.—In the obituary of the late Dr. Fowler Bradnack, published in the June number of the JOURNAL, there is inaccuracy which we are pleased to correct. Dr. Bradnack was twice married; the second time to Mrs. Susie Bulson, of Buffalo, N. Y., this marriage having taken place in New York City, June 21, 1885.

Personal.

DR. GEORGE H. ROHÉ, of Baltimore, has resigned as Health Officer of that city to accept the Superintendency of a Hospital for the Insane near Baltimore.

DR. L. DUNCAN BULKLEY, of New York, has been awarded the Alvarenga Prize of the College of Physicians of Philadelphia for 1891, for an essay on Syphilis Insontium.

PROF. JOHN A. MILLER, Ph. D., of Buffalo, was elected a member of the Executive Committee of the American Microscopical Society, at its recent meeting held in Washington, D. C.

DR. F. B. DARLING, formerly of Westfield, N. Y., has located at 273 Franklin street, Buffalo, for the practice of his profession. His office hours are: 8 to 10 A. M., 2 to 5, and 7 to 9 P. M.

DR. RUSSELL BELLAMY, of Wilmington, N. C., won the "Appleton Prize," in Asheville, last month, he having stood the best examination out of eighty applicants for license before the State Examining Board.

H. M. WHELPLEY, Ph. G., M. D., F. R. M. S., has been elected Professor of Physiology and Histology, and Director of the Histological Laboratory of the Missouri Medical College, St. Louis, as well as Secretary of the faculty.

DR. E. E. MONTGOMERY, of Philadelphia, spent the month of August on the Pacific coast, where he attended a number of medical society meetings, thus combining professional work and recreation in a most agreeable manner. He was accompanied by Mrs. Montgomery.

Dr. John H. Rauch, of Chicago, has tendered his resignation as Secretary of the Illinois State Board of Health. The medical profession of the United States owes Dr. Rauch an everlasting debt of gratitude for his services in the interest of higher medical education. He has waged an unrelenting warfare against all forms of ignorance and irregularity in medicine for many years, and his retirement from his labors is to be regretted. But it must be confessed that he has well earned his much-needed rest, and we wish him long years of enjoyment, with his blushing honors so thick upon him.

A Good Selection.—Gen. James A. Beaver, late Governor of Pennsylvania, a scholar, a lawyer, a soldier, and a man of fine attainments, has recently been selected as President of the Board of Trustees of the Philadelphia Dental College in place of the late Governor Pollock. General Beaver, who has always taken so much interest in the scientific, educational and charitable institutions of this State, will make an able head to this worthy school. The college at this time is one of the best equipped, and has one of the most distinguished lists of teachers in the world. Large numbers of students from every portion of the civilized world annually seek the halls of this college.—*Medical Bulletin.*

Society Meetings.

The American Public Health Association will hold its nineteenth annual meeting at Kansas City, Tuesday, Wednesday, Thursday, and Friday, October 20, 21, 22, and 23, 1891.

The following topics have been chosen for consideration at this meeting: (1) Sanitary Construction in House Architecture; (2) Railroad Sanitation; (3) Meat Supplies; (4) Milk Supplies of Cities; (5) Arsenical Papers and Fabrics; (6) Isolation Hospitals for Infectious Diseases in Cities.

Among its officers and members of committees, we notice the names of several Buffalo physicians: Dr. Edward Clark is a member of the executive committee; also on the special committee on the Disposal of Garbage and Refuse. Dr. F. P. Vandenbergh is one of the committee on the Pollution of Water Supplies. Dr. W. D. Greene is on the committee on the Cause and Prevention of Diphtheria.

The Mississippi Valley Medical Association will hold its seventeenth annual session at the Pickwick Theatre, Washington and Jefferson avenues, St. Louis, October 14th, 15th, and 16th. A full programme of interesting papers has been prepared and provision has been made for the fullest, freest and most complete discussion of the same. Representative men from various sections of the country have been invited to open the discussions. The local profession of St. Louis is a unit to the end that every visiting physician shall be received and welcomed in a regular warm-hearted St. Louis style. The same qualifications for membership are requisite in this Association as for the American Medical Association, the former being subordinate to the latter. All eligible physicians and their friends, together with their wives and families, are most cordially invited to visit St. Louis and enter into the scientific work and the social pleasures as they may desire.

I. N. LOVE, M. D., Chairman,
Committee Arrangements.

The Third Annual Meeting of the Tri-State Medical Association will convene in Turner Hall, Chattanooga, Tenn., Tuesday, October 27, 1891, and continue in session three days. Indications are that it will be one of the largest medical meetings ever held in the South. Representative physicians from all sections will be present.

All who desire to read papers should send title to the Secretary of the Association, Dr. Frank Trester Smith, before September 1st. In due time a circular will be issued, giving a complete list of all papers and names of exhibitors who apply for space before October 1st.

W. L. GAHAGAN,
Sec'y of Executive Com.,
P. O. Box 542. Chattanooga, Tenn.

The American Association of Obstetricians and Gynecologists will hold its fourth annual meeting, at the New York Academy of Medicine, 17 West Forty-third street, in the City of New York, Thursday, Friday, and Saturday, September 17, 18, and 19, 1891, under the presidency of Dr. Adam H. Wright, of Toronto. All physicians interested in the discussion of subjects pertaining to Abdominal Surgery, Obstetrics, and Gynecology, are invited to attend without further formal notice. By order of the Executive Council.

The Canadian Medical Association will hold its twenty-fourth annual meeting in Montreal, on Wednesday, Thursday, and Friday, 16th, 17th, and 18th September. Members desirous of reading papers or presenting cases will kindly communicate with the secretary, Dr. H. S. Birkett, 123 Stanley street, Montreal, as to title of paper or nature of case, as early as possible. Arrangements are being made with the various railway and steamboat companies, whereby members can obtain return tickets at considerably reduced rates.

The American Orthopedic Association will hold its fifth annual meeting in the new reception room of the Arlington Hotel, Washington, D. C., Tuesday, Wednesday, Thursday, and Friday, September 22, 23, 24, and 25, 1891, under the presidency of Dr. A. B. Judson, of New York. An interesting programme, consisting of sixty-seven papers on important subjects by able men throughout this and foreign countries, has been prepared, and a profitable meeting may be predicted.

The American Electro-Therapeutic Association will hold its first annual meeting at the Hall of the College of Physicians, corner Locust and Thirteenth streets, Philadelphia, Pa., Thursday, Friday, and Saturday, September 24, 25, and 26, 1891, under the presidency of Dr. G. Betton Massey.

Physicians interested in the discussion of electricity in medicine are invited to attend without further notice.

Obituary.

Dr. James W. Craig, of Churchville, Monroe county, N. Y., died at his home on Friday, June 26, 1891, aged 65 years. Dr. Craig was one of the best known and ablest physicians in his region, and his friends, neighbors, patients and relatives will keenly feel and deeply lament his demise. His death resulted from septicemia, caused by the prick of a pin in one of his fingers, which occurred on the 17th of May last. Dr. Craig was born November 8, 1825, in the town of York, Livingston county. He was the son of William and Jane Craig, of Scotch descendants, received an academic education, and attended schools in Le Roy and Geneseo, under the tutorage of Rev. Donald D. McCall. He studied medicine with his

uncle, J. R. Craig, M. D., of Mumford, and attended medical lectures at the University of Pennsylvania, at the University of Buffalo, and at the Jefferson Medical College, of Philadelphia. He commenced practice in Churchville, April 1, 1851, and had continued the same until a short time before his death.

He was married to Sarah S. Butterfield, of Caledonia, September 2, 1851. Six daughters were the result of this marriage, two dying in infancy. The four living are: Mrs. Jennie, wife of Rev. John B. Jones, of Tama, Iowa; Dr. Sarah Craig Buckley, now in Kyoto, Japan; Dr. Marian Craig, Lake avenue, Rochester, and Dr. Anna Craig, associated with Dr. Marian. His second marriage took place May 7, 1890, to Mrs. Almira Doty Borst, with whom he was living at the time of his death. Dr. Craig was honored by many responsible positions at the hands of his fellow-physicians, and had been a Curator of the Buffalo University Medical College for many years.

Journalistic Notes.

A Magazine Written by Women.—As was expected, the greatest interest has been exhibited in the new story by Amélie Rives which was begun in the August number of the *Cosmopolitan*. The second part appears in the September number and the story will close in the following issue.

The September issue of the *Cosmopolitan* Magazine is a "woman's number" so far as the authorship of its articles is concerned, but the general interest of the periodical is sustained by the variety and timeliness of the topics treated. The opening article, on Edouard Detaille, is by Lady Dilke, and is profusely and beautifully illustrated with reproductions of the famous artist's most noteworthy paintings. A Forgotten City, by Eleanor Lewis, is a romantic description of the ruins of Soluntum, the Sicilian Pompeii, embellished with photographs. Malmaison in the Market, by Mary Bacon Ford, describes the waning fortunes of the house celebrated for the residence there of the ill-fated Empress Josephine. Julia Hayes Percy describes the Ladies' New York Club in an entertaining article, to which Harry Fenn has contributed illustrations. Elizabeth Bisland writes of Tattersall's, the great London horse market, and the family who have given it name and fame. Molly Elliott Seawell contributes The Romance of

Count Königsmark, the titled adventurer for whom the wife of George I. of England spent thirty years in prison; and the Countess Ella Norraikow writes of Woman's Share in Russian Nihilism, her article being illustrated with portraits of many fair conspirators. There are, besides, papers on the Evolution of the Society Journal, by Mrs. Roger A. Pryor; Society Women as Authors, by Anna Vernon Dorsey; a pretty story, Il Mandolinista, by Daisy O'Brien, and verses by Katherine Grosjean, Mrs. Charles B. Foote, and Susan Hartley Swett, all the important articles being liberally illustrated.

The *New England Medical Monthly* has issued its September number in souvenir form, to commemorate its tenth anniversary. It is printed on heavy plate paper, and contains an autotype frontispiece of the Editor-in-Chief and his associate editors. Besides, scattered through the journal are full-page plates of a large number of the distinguished physicians of the United States and foreign countries. This souvenir number is a monument to the ability, generosity, and indefatigability of Dr. William C. Wile, who conducts this interesting and valuable journal.

The *Climatologist* has made its appearance. It is a monthly journal of medicine, devoted to the relation of climate, mineral springs, diet, preventive medicine, race, occupation, life insurance, and sanitary science to disease, edited by John M. Keating, M. D., J. P. Crozer Griffith, M. D., and Charles F. Gardiner, M. D., with a number of distinguished associate editors. It is published by W. B. Saunders, 913 Walnut street, Philadelphia, Pa.

Anales del Departament Nacional de Higiene is the name of a new journal just published in Buenos Aires. It is devoted to the study of hygienic questions, legal medicine, bacteriology, climatology, meteorology, etc. Judging from its first number, it is bound to be a success, and in keeping with the high standard enjoyed by the medical journals of the Argentine capital.

Medical College Notes.

The Medical College year is about to commence, and before another issue of the Journal the two schools in this city will be in full blast. The Buffalo University will open on Monday, September

28, 1891, and announces a three years' course of graded instruction, in compliance with recent laws, and in keeping with the general advance of public sentiment on the subject of improved medical education. The Niagara University will open its regular collegiate year on Monday, September 21, 1891, with an introductory address by Prof. Herman Mynter, M. D. This school has always required three years of instruction, and was organized on the graded plan. It now contemplates advancing to four years of graded instruction as a requirement for its degree.

We have given in our issues for June and July the recent changes in the faculties of these two schools.

The medical department of Tulane University was made, June 13th, the recipient of a generous donation from Mrs. Richardson, wife of that eminent physician and dean of the college, Dr. T. G. Richardson, of $100,000. The entire donation is intended to be used in erecting a new college on Canal street, between Vilere and Robertson, the site for which was bought a few days ago for $35,000 by the Educational Board.

The faculty of the medical department of the university has selected Dr. Edmund Souchon, Professor of Anatomy and Clinical Surgery, as its representative in the selection of the proper sort of building for the purpose intended. Dr. Souchon will soon leave for the North and East to examine various colleges to guide him in the selection of a building that will be best suited to the wants of the local institution.—*Medical Bulletin.*

Reorganization of the Chicago College of Physicians and Surgeons.— The coming collegiate year will be marked by a number of radical changes in the above institution ; several gentlemen have resigned and a number of new professors have been elected. Among the new men are Dr. Bayard Holmes, surgical pathology ; Dr. Boerne Bettman, ophthalmology ; Dr. James A. Lydston, professor of chemistry and lecturer on ophthalmology and otology ; Dr. Weller Van Hook, general pathology ; Dr. E. E. Babcock, clinical medicine and diseases of the chest ; Dr. G. Frank Lydston, surgical diseases of the genito-urinary organs and venereal diseases.

The college already has an excellent reputation, and the elements of strength which have been added to the faculty will undoubtedly contribute to the usefulness and renown of the institu-

tion. The increased confidence of the alumni of the institution augers well for its future prosperity. — *Western Medical Reporter.*

At the Medico-Chirurgical College of Philadelphia, Prof. E. Laplace has been elected to the chair of Surgery; J. M. Anders, to that of Practice of Medicine; and E. E. Montgomery, to that of Obstetrics. Thus, each of the vacancies in the great didactic chairs has been filled by men already members of the faculty. Prof. Geo. E. Stubbs will probably resign the chair of Surgical Pathology, leaving only Prof. Gerhard to represent the faculty that created this college ten years ago.—*Medical Bulletin.*

The announcement of the Long Island College Hospital for 1891 contains the following items of interest: The regular course of lectures will hereafter be six months in duration. Three courses of lectures will hereafter be required for graduation. Joshua M. Van-Cott, Jr., M. D., has been appointed Professor of Histology and Pathological Anatomy, *vice* Frank Ferguson, M. D., who has resigned.

Book Reviews.

A Manual of the Practice of Medicine. By Frederick Taylor, M. D., F. R. C. P., Physician to, and Lecturer on Medicine, at Guy's Hospital; Physician to the Evelina Hospital for Sick Children; Examiner in Materia Medica and Pharmaceutical Chemistry, at the University of London. With illustrations. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut street. 1890.

This is a very good text-book, and deserves a place in the front rank, beside Roberts and Strümpel. The section on the Methods of Procedure in Examination of the Nervous System is especially good.

In the remarks on Physical Diagnosis there is one statement that is misleading, viz.: "In certain parts of the chest the vesicular murmur gives place to a sound having the character which will be presently described as those of bronchial breathing. These parts are the upper end of the sternum, the first costal cartilages at their junction with the sternum, and a diamond-shaped span at the back in the middle line, including the seventh cervical and first dorsal spines. Elsewhere the vesicular murmur is always present, as long as the lung is healthy and the air passages pervious." A grave

error is here made in not stating that the breathing in the right infra-clavicular region is much more bronchial in character than that in the left, being of a longer expiratory sound, and of higher pitch. This is an important point, as, if not thus instructed, a young practitioner might make the serious mistake of diagnosticating an infiltrated right apex, merely from the normal physical signs, especially as the percussion note in that region is also of a higher pitch than in the corresponding area on the left side.

In the section devoted to the Diseases of the Stomach no mention is made of the use of the stomach-tube for purposes of diagnosis. This is a serious omission, for the tube is of even greater value as a means of diagnosis than as a means of treatment.

Another omission of serious import is that of the therapeutic uses of inhalations of oxygen gas, as in the various forms of anemia, in pneumonia, and in edema of the lungs.

The section devoted to Diseases of the Heart is very clear and concise.

With the few exceptions noted above, the book is, on the whole, to be highly recommended. DE L. R.

PRACTICAL POINTS IN THE MANAGEMENT OF SOME OF THE DISEASES OF CHILDREN. By I. N. LOVE, M. D., Professor of Diseases of Children, Clinical Medicine and Hygiene in the Marion-Sims College of Medicine, St. Louis; Consulting Physician to the City Hospital, St. Louis, etc., etc. The Physicians' Leisure Library. Detroit: George S. Davis. 1891. Price, cloth, 50 cents; paper, 25 cents.

There is no more important department of medicine than that which is concerned in the management of the diseases of children. By judicious care in the early weeks or months of child life, many of the maladies and deformities that mar symmetry or affect health in after years may be avoided. It is a field in which an especial aptitude is required to successfully conduct practice, and only a few men seem to be gifted with the tact requisite to do so. The author of this little volume is eminently one of those men who may be termed a master in the department of pediatrics, and who never writes with an uncertain or diffident pen. If we had space at hand it would be interesting to quote at length from Dr. Love's admirable book. We cannot refrain, however, from bringing out one point, which is of such particular importance as to demand attention from every person concerned in the care of infants. Dr. Love says on page thirty-nine:

Let us not forget that in guarding the skin of children as well as

adults, we should keep in proper condition the alimentary canal primarily, and urge upon those under our care the importance of the hygiene of the skin, bathing at least once a day with tepid water and a proper kind of soap. Dr. Merrill B. Ricketts, of Cincinnati, at a recent meeting of the Mississippi Valley Medical Association, presented a paper upon skin diseases resulting from the abuse of soaps, wherein he made very strong points. Undoubtedly there is not proper discretion exercised on the part of the household in the selection of soaps for domestic use. White castile soap is a good all-around soap, but one of the best for use in the nursery is Pears' soap, and in spite of the fact that somebody may benefit by this special commendation, I am ready to maintain the position, and present in justification the fact that probably the highest authority in the world upon the skin, Sir Erasmus Wilson, has publicly taken the same position.

We regard this one of the most important publications in the Leisure Library series, and should recommend every physician to possess it, for it is equally as useful in the household as in the medical library.

FEVER: ITS PATHOLOGY AND TREATMENT, BY ANTIPYRETICS. Boylston Prize Essay of Harvard University, July, 1890. By ROBERT AMORY HARE, M. D., B. Sc., Clinical Professor of Diseases of Children and Demonstrator of Therapeutics in the University of Pennsylvania; Physician to St. Agnes' Hospital and to the Children's Dispensary of the Children's Hospital, etc. No. 10 in the Physicians' and Students' Ready Reference Series. Philadelphia and London: F. A. Davis. 1891. Price, cloth, $1.25 net.

In this little book will be found a thorough discussion of the value of antipyretics in the treatment of fever. Hare divides them into three classes: first, those which inhibit the production of fever; second, those which decrease the production and increase the dissipation of bodily heat; third, those which increase the radiation of heat so that the loss is greater than the supply. The first class the author believes to be the ideal, but unattainable, as there are no drugs capable of accomplishing it; the second class comprises most of the antipyretic drugs that are properly employed in the treatment of fever, while the third class are unreliable and harmful. Drugs of the second class are antipyrin, antifebrin, carbolic acid, salicylic acid and quinine; and those of the third class are cardiac sedatives like aconite and antimony. We quote from Hare the following, which possesses a special interest:

Antipyrin stands today foremost in the ranks of the antipyretics, with antifebrin next, while thallin and phenacetin follow, with perhaps a preference for the latter. These conclusions are in regard to the

reduction of fever. In pain the arrangement should somewhat be changed. Antipyrin still takes the lead, but phenacetine is quite as useful as antifebrin and seems more safe. Thallin possesses hardly such power. In rheumatism, of course, the salicylates act better than the rest of the class of antipyretics, particularly in reference to the pain and the cure of the disease itself, but the others control the fever of rheumatism in a much more effective manner.

Since this book was published, Dr. Hare has been appointed Professor of Therapeutics and Materia Medica, in the Jefferson Medical College, and his opinions become all the more attractive. This work will be read with interest by physicians as well as students, and is an ably prepared *résumé* of the subject.

ORIGIN, PURPOSE, AND DESTINY OF MAN; OR, THE PHILOSOPHY OF THE THREE ETHERS. By WILLIAM THORNTON. 12mo, pp. 100. Boston: Published by the author. 1891.

Some idea may be gathered of the purposes of the author of this book, if we quote a paragraph or two from his introduction. Thornton says :

Life I call the first ether which is a continuous aggregate ; the second ether I call a composition of the potentialities heat, light, electricity and magnetism ; mechanical power being manifested during the activities of these potentialities. The third ether is a material nucleus which permits of the action of the other two ethers. All bodies manifesting the second and third ethers independently of the first, make up all inorganic bodies. Organized bodies require all three ethers.. These two conditions constitute all things natural and supernatural.

In the first chapter is discussed the philosophy of the three ethers ; in the second, how to make medicine a science ; in the third, the germ theory of disease ; in the fourth, the transmission theory of disease ; in the fifth and last, immortality. It is difficult to pass such a book in critical review, without devoting more time and space than we have at command, but we can assure our readers of an interesting afternoon if they chose to occupy it in reading the volume. Whether it brings one nearer to the knowledge of the infinite, we leave to the judgment of each individual who communes with the author.

TRANSACTIONS OF THE AMERICAN GYNECOLOGICAL SOCIETY. Vol. XV. For the year 1890. Small octavo, pp. xxxix.—411. Philadelphia : William J. Dornan. 1890.

This volume of the Transactions of this distinguished Society is a record of the work it performed in Buffalo last year. The papers

are for the most part of a high order of merit, and the discussions are interesting and pointed. Perhaps one of the strongest papers in the book is that of Dr. J. M. Baldy, on the Diagnosis and Treatment of Early Ectopic Gestation, and another by Dr. Ed. W. Jenks, on the Resemblance of Some Forms of Benign Disease to Malignant, deserves special mention: but it is a volume that must be seen to be appreciated, and read to be understood. We may affirm, without fear of exaggeration, that it is a book that necessarily must be found on the shelves of every progressive man who teaches or practises gynecology at the present day.

THE POCKET ANATOMIST. Founded upon Gray. By C. HENRI LEONARD, A. M., M. D., Professor of the Medical and Surgical Diseases of Women and Clinical Gynecology, in the Detroit College of Medicine. Fourteenth revised edition, containing Dissection Hints and Visceral Anatomy. Detroit, Mich., 1891. The Illustrated Medical Journal Co., Publishers. Cloth, 297 pages, 193 illustrations: price, postpaid, $1.00.

This book is issued on thin, though nicely glazed paper, and takes up but little room, though 300 pages in thickness. The plates introduced are photo-engraved from the English edition of Gray, and are, therefore, exact; most of them are full-paged, and where they are not, they are grouped together so as to save us much thumbing as possible. The useless "questions" are absent in this work, and their room given to needed illustrations or terse descriptions of the minor parts found in the several dissections made. The chapter given to Dissection Hints gives the lines of incision necessary to best expose the underlying organs, arteries, nerves, or muscles. The chapter on Gynecological Anatomy can be found only in the more expensive work of Savage. The pronunciation of each anatomical term is given, be it artery, vein, nerve, muscle, or bone. Over 100 pages are devoted to the anatomy of the special organs and viscera. The book has been honored by a reprinting in England after some 3,000 copies had been sold over there by the American publishers.

TRANSACTIONS OF THE ASSOCIATION OF AMERICAN PHYSICIANS. Fifth Session, held at Washington, D. C., May 13, 14, and 15, 1890. Volume V. Cloth, 8vo, pp.—275. Edited by I. MINIS HAYS, M. D., Recorder. Philadelphia: Printed for the Association. 1890.

The fifth volume of the Transactions of this distinguished Association does not differ greatly from those that have preceded it in make-up or in interest. It records in a plain, straightforward,

readable manner the transactions of the Association at its Washington meeting last year, and contains many papers of unusual interest. The paper of Dr. Lusk, on Antisepsis in Midwifery, and that by Dr. Shakespeare, on What Can be Done to Limit the Prevalence of Tuberculosis in Man, are especially to be commended for their able handling of important topics. The volume is edited by an experienced recorder, and is printed by Dornan, who has an especial aptitude for bringing out society transactions in proper shape.

PLAIN TALKS ON ELECTRICITY AND BATTERIES, WITH THERAPEUTIC INDEX. For General Practitioners and Students of Medicine. By HORATIO R. BIGELOW, M. D., Permanent Member of the American Medical Association; Fellow of the British Gynecological Association; Member of the Philadelphia Electro-Therapeutic Society, etc. 12mo. pp. vi.—85. Philadelphia: P. Blakiston, Son & Company. 1891.

There is one comfort about this little volume, and that is its brevity. It seems to us, however, that it tells pretty nearly all there is to be told on the subject of which it treats. In that sense it is useful, as it gives the definitions of, and describes the various questions of electricity, together with the office paraphernalia necessary to their employment. It has the usual number of illustrations of different batteries with the patentee's name prominently engraved upon them. This is all very well, and quite in keeping with the work, but we are at a loss to know what can be learned from the handsome cut on page seventy-five. The publishers have printed the book in an excellent manner.

THE ACTION, THERAPEUTIC VALUE, AND USE OF THE CARLSBAD SPRUDEL SALT (POWDER FORM), AND ITS RELATION TO THE CARLSBAD THERMAL WATER. By Dr. W. JAWORSKI, Demonstrator at the University of Krakow. Clinical experiment researches made at the University Clinic of Professor Korczynski, in Krakow, with a Dietary by the translator, A. L. A. Toboldt, M. D., Assistant Demonstrator of Pharmacy, University of Pennsylvania; Editor *Journal of Balneology and Medical Clippings*. 8vo. pp. viii.—100. Philadelphia: P. Blakiston, Son & Company. 1891.

The importance of an understanding of the subjects treated of in this book is constantly on the increase. Physicians are more and more growing into the habit of prescribing mineral waters in the management of disease; hence, it is important that the therapeutic action of these waters shall be well understood. Carlsbad waters have occupied a deservedly high place in treatment of various

maladies, and we advise those who are not already familiar with their therapeutic value to purchase this treatise.

A Guide to the Practical Examination of Urine. For the use of Physicians and Students. By James Tyson, M. D., Professor of Clinical Medicine in the University of Pennsylvania, and Physician to the Hospital of the University; Fellow of the College of Physicians of Philadelphia, etc., etc., etc. Seventh edition; revised and corrected, with a colored plate and wood engravings. Pp. —255. P. Blakiston, Son & Co. Philadelphia: 1891.

This little work which has just passed through six editions, has no superior in the English language. The subject matter of which it treats is complete without being verbose; it is concise, thorough, and up to date. It is a volume that should be in the hands of every medical student, and in the library of every practitioner. The excellent work usually done by the publishers is easily seen here.

J. A. M.

BOOKS AND PAMPHLETS RECEIVED.

A Text-Book of Practical Therapeutics. With especial reference to the Application of Remedial Measures to Disease and their Employment upon a Rational Basis. By Hobart Amory Hare, M. D., B. Sc., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia; Physician to St. Agnes' Hospital and the Medical Dispensary of the Children's Hospital; Laureate of the Royal Academy of Medicine in Belgium; of the Medical Society of London; Secretary of the Convention for the Revision of the United States Pharmacopeia of 1890. Second edition. Enlarged and thoroughly revised. Cloth and leather, 8vo, pp. xii.—658. Philadelphia: Lea Brothers & Co. 1891.

Practical Pathology and Morbid Histology. By Heneage Gibbes, M. D., Professor of Pathology in the University of Michigan; formerly Lecturer on Normal and Morbid Histology in the Medical School of the Westminster Hospital, London; formerly Curator of the Anatomical Museum, King's College, London. Illustrated with sixty photographic reproductions. Octavo, pp. xii.—320. Philadelphia: Lea Brothers & Company. 1891.

Transactions of the Medical Society of the State of New York for the year 1891. Edited by Frederic C. Curtis, M. D., Secretary of the Society. 8vo, pp. viii.—560. Published by the Society. 1891.

Index-Catalogue of the Library of the Surgeon-General's Office, United States Army. Authors and Subjects. Vol. XII. Reger-Shuttleworth. Quarto, pp. 1004. Compiled by John S. Billings, Surgeon United States Army. Washington: Government Printing Office. 1891.

Report on Cholera in Europe and India. By Edward O. Shakespeare, A. M., M. D., Ph. D., of Philadelphia, United States Commissioner. Transmitted to the Secretary of State. Quarto, pp. xxvi.—945.

Stories of a Country Doctor. By Willis P. King, M. D., member of the American Medical Association; member and ex-President of the Missouri State Medical Association; Assistant Chief Surgeon of the Missouri Pacific Railway Company: formerly Lecturer on Diseases of Women in the Medical Department of the Missouri State University, and Professor of Diseases of Women in the Medical Department University of Kansas City; Lecturer on Orthopedic Surgery and Clinical Surgery in the University Medical College of Kansas City, etc., etc. Second edition. With Illustrations by T. A. Fitzgerald. Philadelphia: A. L. Hummel, M. D., publisher. 1891. Price, $1.00, bound in cloth.

Transactions of the Texas State Medical Association. Twenty-third Annual Session held at Waco, April 28, 29, 30, and May 1, 1891. Edited by Hamilton A. West, M. D., Secretary. Galveston: Clarke & Courts. 1891.

Transactions of the Twenty-fourth Annual Session of the Medical Association of the State of Missouri held at Excelsior Springs, May 19, 1891. Edited by Lyman A. Berger, M. D., Secretary. Kansas City: Tiernan-Havens Printing Co. 1891.

Addresses, Papers, and Discussions in the Section of the Practice of Medicine and Physiology at the Forty-second Annual Meeting of the American Medical Association, at Washington, D. C., May 5, 6, 7, and 8, 1891. Chicago: Printed at the Office of the Association. 1891.

Practical Intestinal Surgery. Vol. II. By Fred. B. Robinson, B. S., M. D., Professor of Anatomy and Clinical Surgery, Toledo (Ohio) Medical College; *Physicians' Leisure Library.* Issued monthly. Detroit: George S. Davis. 1891. Price, cloth, 50 cents; paper, 25 cents.

The Mother's Hand-Book. A Practical Treatise on the Management of Children in Health and Disease. With an Appendix containing Articles on Diseases and Accidents that may suddenly happen to grown persons. By Levin J. Woollen, M. D. Richmond, Va.: Everett Waddy Co. 1891.

The Steps of the Cesarean Section. The Do's and Don't's. By H. A. Kelly, M. D. Reprint: American Journal of Obstetrics. Vol. XXIV. No. 9. 1891.

Proceedings and Addresses at a Sanitary Convention held at Charlevoix, Mich., August 14 and 15, 1890. Supplement and Reprint. Report Michigan State Board of Health. Lansing. 1891.

Third Annual Report of the Health Department, Mansfield, Ohio. 1890-91. By R. Harvey Reed, M. D., Health Officer, Mansfield. 1890.

Amputations in the Light of Prothetical Science. By Charles Truax, Chicago, Ill. Reprint.

Eye Diseases of the Unborn. By Julian J. Chisolm, M. D. Reprint: *Maryland Medical Journal,* May 30, 1891.

Can the Gynecologist Aid the Alienist in Institutions for the Insane? By I. S. Stone, M. D., Washington, D. C. Fellow American Association of Obstetricians and Gynecologists; Gynecologist to the Columbia Hospital, etc. Reprint: *Journal American Medical Association,* June 20, 1891.

The Direct Treatment of Diseased Tubes and Ovaries. By A. V. L.

Brokaw, M. D., St. Louis, Mo. Reprint: The *Medical Mirror*, July, 1891.

A New Intestinal Clamp. By A. V. L. Brokaw, M. D., Demonstrator of Anatomy and Operative Surgery, Missouri Medical College, etc. Reprint: *State Medical and Surgical Journal*, October, 1890.

Status Epilepticus. By G. R. Trowbridge, A. M., M. D., and C. B. Mayberry, A. M., M. D., Fellows of the American Academy of Medicine: Assistant Physicians State Hospital for the Insane, Danville, Pa. Reprint: *Journal of Nervous and Mental Diseases.* July, 1891.

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Miscellany.

MEDICAL SOCIETY OF THE STATE OF NEW YORK.—The Secretary is authorized to offer to the County Societies, and to other Societies which send delegates to this Society, such of the back volumes of the *Transactions* as are in his hands, to complete, so far as they may, their files of this publication. For the information of such Societies as may wish to avail themselves of this, he would state that at present (1891) there are on hand *Transactions* of the following years:

1807–31 (Reprint in one volume.)	1861
1840—43 (Reprint in one volume.)	1864
1860	1868

and all succeeding years to the present time; of some, the number of copies on hand is limited.

Any of these issues that may be lacking will be sent gratuitously to all Societies that have already subscribed for their quotas (five copies to each delegate sent) for past years, or that will subscribe for their quotas for 1890 and 1891 if they have not already done so. It is thought very desirable that each Society should provide itself with as complete a file as possible of these volumes, and preserve them carefully in its own possession. Some of them cannot be easily replaced, and a complete set is practically a history of medicine in this State for this century. Some County Societies that have subscribed for them have failed to preserve complete sets, and some have not subscribed regularly; it is to be hoped that they may all do so hereafter. Societies receive their quotas at $1.25 per volume; to others the price is $1.50, and, for issues prior to 1887, fifty cents.

Requests for volumes wanted as above set forth may be sent to the Secretary, Dr. F. C. Curtis, 17 Washington avenue, Albany, or the Treasurer, Dr. C. H. Porter, 103 Lancaster street, Albany.

The American people are undoubtedly to-day the greatest reading people in the world. Even in very humble households you will find a magazine, one or two weekly papers, and a half dozen shelves of books; the cabinet maker furnishing in these days a very elegant oak book-case for $8.00. There are three classes of publications which are found in almost every household—books, the weekly paper, and the monthly illustrated magazine. The weekly paper gives all the news of the week, keeps the subscriber posted upon what is going on in the markets and in politics. The illustrated magazine, owing to the fact that it is seldom published in numbers less than 100,000, can afford to pay the highest prices for both literary and artistic work, and offers at a figure so low that it seems impossible, the serious, sober thoughts of the great writers of the world, in addition to those of masters of fiction, together with lighter and more entertaining sketches.

When the public was first presented with an illustrated magazine for $4.00, and a weekly at $2.00, it was thought that great progress had been made in giving much for little. What must be thought then of a proposition which gives a magazine like the *Cosmopolitan*, the rival of the best of the $4.00 magazines, a monthly of sixty-four pages, closely printed like the Buffalo Medical and Surgical Journal for $2.00, and then, to cap the climax, throws in for 50 cts. the publishers' regular subscription edition of a copyright work like Grant's Memoirs, sold at $7.00; not a cheap reprint, but on the best paper, handsomely bound in cloth, green and gold, in every respect the same edition as has hitherto been sold at $7.00 —$5.00 (not including postage on Memoirs) for the entire combination. Such an offer constitutes an event in the history of book publishing. It has never been done before, and probably will never be repeated, unless some of the older magazines should likewise aspire to build up their circulation to half a million copies.

Notice to Contributors. — We are glad to receive contributions from every one who knows anything of interest to the profession. Articles designed for publication in the Journal should be handed in before the first day of the month. The Editors are not responsible for the views or opinions of contributors. All communications should be addressed to the Managing Editor, 284 Franklin Street, Buffalo, N. Y.

Buffalo Medical and Surgical Journal

Vol. XXXI. OCTOBER, 1891. No. 3.

Original Communications.

AFFECTIONS OF SIGHT FROM INJURIES.[1]

By ALVIN A. HUBBELL, M. D.

Professor of Ophthalmology and Otology in the Medical Department of Niagara University, Buffalo, N. Y.

The results of injuries in general are very various, and often most complex and obscure. It requires a broad acquaintance and great familiarity with the multiformity of contusions, punctures, lacerations, fractures, incisions, and concussions which may be inflicted upon the different parts and structures of the human body, in order to truly estimate their effects, and to direct and carry out the proper treatment. Permit me, therefore, to introduce for discussion at this time a subject that is not new, but that will profitably bear reconsideration, especially in the light of certain researches that have recently been made in the anatomy, physiology, and pathology of the central nervous system, viz., that class of injuries that may affect vision.[2]

Those injuries which may affect vision may do so directly or indirectly; immediately or after the expiration of a period of time; temporarily or permanently.

Directly, an injury usually affects vision by implicating the eyeball or its muscles. It may, however, involve the optic nerve, and even the visual path within the cranium, viz., the optic tract and the optic fibers within the basal ganglia, internal capsule, and "radiations of Gratiolet" in the white substance of the brain, and, also, the visual center in the cortex of the occipital lobe. Concussions, contusions, and hemorrhages may produce the lesions, or they may arise less remotely by lacerations, cuts, and pressure directly inflicted by the missile, foreign substance, or displaced bone.

1. Read, May 12, 1891, before the Fourth Branch of the New York State Medical Association.

2. It will not be in keeping with the brevity at which I aim to introduce in this paper illustrative cases, although I would be glad to do so.

Indirectly, the visual apparatus may become affected by pressure through other parts, by reflex influences, by disturbances of the sympathetic nervous system, and by extension from a distant point of injury of some pathological process, such as inflammation or degeneration due to vaso-motor or other changes. Almost any part of the visual apparatus may thus suffer.

Immediate impairment of vision may come from both direct and indirect injuries, but it usually follows direct, while that which comes on after the lapse of more or less time, usually follows indirect.

The vision is more likely to be *temporarily* affected in those injuries which disturb it immediately, while its loss is more likely to be *permanent* if several weeks or months elapse after the injury before it becomes felt. Again, whether vision be temporarily or permanently impaired, directly or indirectly, immediately or remotely in time, depends upon the nature and extent of the injury and the pathological sequences which it induces.

The forms of visual disturbances may vary greatly according to the parts injured. If the muscles of the ball, or their nerve-supply, are the suffering parts, the normal and coördinating movements of the ball are prevented. There is then an inability to fix both eyes simultaneously upon the same object, or, in other words, binocular vision is interfered with, and diplopia, or double vision, takes place. This diplopia is very annoying, and often distressing, by calling forth such nervous phenomena as vertigo, staggering, nausea, and vomiting. It often compels the patient to desist from all efforts at binocular vision, and to look with one eye alone. In such cases the acuteness of vision may, however, be perfectly normal in each eye.

In case the intra-ocular, or ciliary muscle, or its nerve-supply suffers from injury, the pupillary movements are weakened or destroyed, the pupil is abnormally dilated, and there is an inability to focus or accommodate the eye for near objects. This loss of accommodation often causes great alarm to the patient, and he fears imminent blindness. But such loss does not cause blindness. If this were true, every normal eye would become blind after forty-five years of age, as ordinary presbyopia, or old-age sight, is but the loss of this power. If, through injury, an emmetropic, or normally refractive eye, becomes thus affected, vision for distances of twenty feet or more will still be found to be normal, and proper convex glasses will enable such an eye to see distinctly at any

shorter distance. The acuteness of vision, then, remains unimpaired, and only the ability to change the focus has been diminished. If, however, an eye of a person under forty was hypermetropic or astigmatic before his accommodation had thus been destroyed, then the unaided vision becomes impaired for all distances, while before the injury it may have been fairly good, as the existing refractive error could be completely or in great measure overcome. It may be shown that the impaired vision is due to the refractive error, which loss of accommodation now prevents the patient from overcoming, by neutralizing the error with proper glasses. Then the vision becomes as acute, or perhaps more acute, than before the injury.

The existence of refractive errors in such cases is liable to lead the surgeon astray, unless they be carefully looked for and measured, and the vision tested under proper correction with glasses. The traumatically induced "asthenopia," or "weak vision," of the older observers was simply this loss of power of the ciliary muscle.

One eye alone being thus affected by an injury, the unequal focussing power of the two eyes renders binocular vision confusing and often very distressing.

These affections of the extra- and intra-ocular muscles of the eye do not, therefore, strictly impair the acuteness of vision, but often greatly disturb it, and, by reflex action, cause various nervous distresses.

Injuries of the eyeball itself may vary from total destruction by cuts, lacerations, and ruptures, to mere concussions, where no organic change can be detected, either externally or internally. The external parts may be wounded or contused in many ways, and at almost any point, and yet vision may be only temporarily impaired. Should the iris or vitreus prolapse through a wound, the case becomes complicated in view of secondary results, which might lead to irreparable loss of sight. The iris itself may be wounded with very little ill-results. Hemorrhages into the anterior chamber, and, indeed, into the vitreus, if not too large, will be absorbed,— the former very readily. Concussion or wound of the crystalline lens causes cataract, with "clouding" of vision, but this may, usually, be removed by some method of absorption or extraction, when, with the proper cataract glass, vision may be fairly good. Dislocation of the lens into the anterior chamber of the eye causes serious secondary effects, unless it is returned behind

the iris or extracted through a corneal incision. Dislocation of the lens backwards into the vitreus produces the refractive condition of aphakia, and vision may be good at first with a cataract spectacle. But after months, or, perhaps, years, the lens acts as a foreign body in the bottom of the eye, and finally destroys vision. When the lens becomes extruded through a wound or rupture of the ball, so much damage is usually done to the parts as to cause entire loss of vision.

Injuries which destroy the transparency or normal curvature of the cornea, correspondingly and permanently impair sight. Traumatic iritis, or irido-choroiditis, with extensive exudation, seriously alters the mobility of the pupil, the transparency of the lens, and the nutrition of the eye, and thus causes permanent loss of sight. Excessive loss of vitreus or extensive hemorrhages into it, are very seldom fully recovered from. If the hemorrhages into the vitreus are small, however, they will be slowly absorbed, and after weeks or months the vision may be regained.

Ruptures, hemorrhages, or detachments of the retina or choroid cause blindness at the parts involved and beyond, along the course of the retinal fibers implicated. When the injury is at or near the macula lutea, sight suffers most. Injuries of these structures are seldom fully recovered from, and they often lead to total loss of vision in the eye affected. Sometimes a mere concussion of the retina, with no discernible structural change in the fundus, will impair vision very much, and even permanently.

An injury complicated by the lodgment of a foreign body within the eye, which cannot be extracted, generally leads to permanent blindness of the injured eye.

In most cases only one eye becomes injured. In case, however, that a foreign body is lodged within the eye and cannot be removed, or a lacerated or punctured wound involves the ciliary region, the loss of sight may not be confined to the injured eye, but the sound eye may become sympathetically diseased, and the vision of this, too, destroyed, the patient thus becoming totally blind.

Contusions or lacerations of the optic nerve from missiles or foreign bodies penetrating the orbit, dislocation of the ball from its socket, pressure on the nerve by fractured bone at the optic foramen, traumatic, orbital cellulitis, large hemorrhages into the optic-nerve sheath, all usually result in blindness of the corresponding eye. Other orbital injuries are generally without ill-results to sight.

Injuries may sometimes be inflicted, and for the most part, indirectly, upon the visual apparatus within the cranial cavity, and are, except in rare instances of large hemorrhages or extensive fractures at the base of the brain, limited to one side. An injury of the fibers constituting the visual path behind the optic commissure, whether in the optic tract, the basal ganglia, the internal capsule, the so-called "optic radiations," or the visual centers in the cortex of the occipital lobe, causes a form of blindness known as hemianopsia, or half-blindness, whose completeness is proportionate to the number of visual fibers injured or pressed upon. When all the fibers are involved, the patient is totally blind in just one-half of each field of vision, and in that half opposite to the path injured. This is due to the peculiar anatomical distribution of these fibers to the eyes, those from the left optic tract dividing at the optic commissure and going to the left half of each retina, and those of the right tract, to the right half of each retina. When this so-called lateral, homonymous hemianopsia exists after an injury, or from any other cause, the proof is almost positive that the lesion is in the course of the visual fibers, somewhere posterior to the optic commissure, or at the visual center in the occipital lobe, but its exact location must be determined by other attending symptoms. If that portion known as the optic tract is affected, the hemianopic pupil-reflex may be elicited. But if behind the basal ganglia, the pupil-reflex is normal. When this form of hemianopsia is present, the patient often declares that he is blind in one eye, but examination shows that he is "half-blind" in both eyes, and on the side of the supposed blind eye. The direct vision is usually fair, and the patient may be able to read the finest print, but continued close use of the eyes is attended by ocular fatigue. In walking or riding, he needs to turn his head frequently toward the affected side to avoid colliding with objects which he might not otherwise see. The ophthalmoscope reveals no change from the normal appearance in the fundus of either eye.

Injuries at the base of the brain, which do not at first affect the sight, may, later, by extension of meningeal inflammation, induce an optic neuritis, with subsequent atrophy, which may seriously impair it. The ophthalmoscope then depicts, at first, the optic disc reddened, with its outlines dimmed, and its circumference fringed with radiating lilac-colored or reddish streaks, and the retinal arteries narrowed and the veins distended and tortuous. In severe cases more marked appearances may be seen. After weeks

or months the ophthalmoscopic picture is changed to that of optic atrophy, with the whitened disc with sharp outlines, and all the retinal vessels diminished in size.

Lastly, the vision, in rare instances, becomes affected by indirect influences, when no part of the visual apparatus has been injured. This most frequently occurs after injury to the spine, especially in the upper part of its extent. The ophthalmoscope may then show the optic nerve to be red and congested, or to be actively inflamed, exhibiting the picture of a mild neuritis. In the process of a long period of time, atrophy of the nerve may also take place, or, on the other hand, resolution may restore the parts to their normal condition. When blindness does occur from this cause, it is generally permanent, although exceptions to this have been reported. The vision is not always affected when the optic disc shows marked pathological changes.

Other ocular changes, besides those found in the optic nerve, are sometimes seen after spinal-cord injuries. These are found in the pupil in one or both eyes. In one patient it may be contracted, and in another, more or less dilated. The reflex of the pupil to light is usually lost in either case. In proportionately few instances, this class of spinal injuries, with or without optic nerve changes, leads to paralysis or paresis of one or more of the extra-ocular muscles.

It is supposed, and undoubtedly with truth, that the pupil-changes arise from the irritability or paralysis of the vaso-motor nerves, which come to the eye through the cervical sympathetic, the subordinate vaso-motor centers in the gray matter of the cord, and the vaso-motor fibers in the lateral columns of the cord, these having their origin in the chief, dominating, or general vaso-motor center situated in the medulla oblongata in the floor of the fourth ventricle.

The ophthalmoplegiæ of all kinds are due to disease of the nuclei of the nerves which supply the muscles of the ball, superinduced by vaso-motor influences initiated by spinal-cord injuries.

There seems to be some specific connection between the optic-nerve disease and spinal-cord disease. But as to how or where this connection exists, is still an undecided question. E. Berger, of Paris (*Archives of Ophthalmology*, vol. xix., 1890, page 429), has recently published an extended review of the subject, and submits the results of his personal investigations. He believes that the optic-nerve lesion, and also the lesions in the posterior columns of

the cord, are primarily due to vaso-motor disturbances at the vaso-motor centers for these structures, situated in the general vaso-motor center of the medulla, and that disease of these centers is caused by inflammation of the ependyma, or lining membrane, of the spinal cord and ventricles of the brain. He supports his position with a plausibility that at least commands consideration. His theory certainly explains many phenomena connected with ocular and other symptoms in spinal-cord degenerations from any cause, which could not, heretofore, be rationally accounted for.

Another indirect cause of blindness is supposed to be some injury of branches of the fifth, or trigeminal nerve, preferably its frontal branch. Many instances of this kind have been recorded, but, most singularly, these, for the most part, occurred in pre-ophthalmoscopic times. Such blindness has been explained by referring it to some indefinable reflex influence brought to bear upon the sympathetic nervous mechanism of the eye in such a manner as to alter seriously the blood circulation or the nutrition of the optic nerve and ball. I cannot deny the existence of such a cause; but in view of the fact that, with the ophthalmoscope, such cases do not appear, I am inclined to believe that in the old cases concussion of the retina, embolism of the retinal artery, hemorrhages or ruptures, could they have been seen, would have accounted for the existence of the "amaurosis."

This presentation, brief though it is, of the various injuries which may be inflicted upon the visual apparatus, and their most probable effects upon vision, shows, it seems to me, that the subject is of sufficient magnitude and importance to emphasize the necessity of giving careful and intelligent attention to this class of cases. In themselves, such injuries do not endanger the life of the individual, they do not furnish large pools of blood, and the tourniquet, Esmarch's bandage, or the amputating-knife and saw, do not figure in the treatment, but they often do rob living of one of the functions and powers most essential to its enjoyment and usefulness. It is, therefore, clearly the duty of the attendant not to look upon these cases lightly, not even those which appear trivial, as these often prove most serious.

A proper investigation and diagnosis of a case of injury to sight not only presuppose a fair knowledge of the anatomical, physiological, and pathological relation of the parts, but they require the use of certain instruments and methods, which should be in the possession of every general surgeon and physician. These should

include, at least, a magnifying lens for focal illumination, an ophthalmoscope for examining the bottom of the eye, test-letters and test-objects for determining the acuteness of vision, and tests for outlining the field of vision. With these means at hand it should be the rule of the surgeon to determine the state of vision at the time of injury, if possible, and at frequent intervals afterwards for some time, as well as the condition of the ball itself as to the presence of wounds, hemorrhages, foreign bodies, etc. Attempts at malingering should be suspected and thwarted. Perhaps refractive errors must be corrected at the hands of an oculist before reliable information as to the exact acuteness of vision can be obtained. Moreover, the sight may have been poor before the accident, and hence a reliable previous history of the state of vision is exceedingly desirable, both from the patient and from second parties. For example, there are many cases of congenital amblyopia of one or both eyes, and particularly in cases of refractive error. The use of tobacco, alcohol, or large doses of quinine often produce visual disturbances of a pronounced character. Many chronic diseases of the fundus of the eyes cause loss of vision, and, if confined to one eye, may exist for a long time, and without the patient having become cognizant of it. All these conditions must be eliminated from the case in determining whether the injury is the true cause of blindness or not.

A correct diagnosis having been made, the course for the surgeon to pursue is first to prevent as little secondary damage as possible, and second, to administer to the subsequent pathological processes as they arise. When the ball is irretrievably lost, or a foreign body is lodged within it which cannot be extracted, he should enucleate or eviscerate it without delay. The responsibility of allowing a patient to go totally blind by sympathetic ophthalmia, through a vain effort to save an eye whose usefulness is totally destroyed, or by permitting the objections of unreasoning persons to prevail, is too great for any man to carry. The injury and blindness of one eye is a great calamity, but the calamity is far greater, and the blame almost inexcusable, when a lost eye is unnecessarily allowed to be the means of putting the patient in utter darkness the remainder of his life.

A large cut of the ball may be treated antiseptically, and the wound closed with fine silk sutures. Prolapsed iris should be excised at the first dressing, as it can scarcely ever be returned into the eye and kept there. Protruding vitreus may be excised

and the wound closed by suture or compress. Wounds of the lens and iris should be treated with four- to eight-grain solutions of atropia. Sometimes the lens can be extracted through a linear incision in the cornea, when, after a few days, it has become generally opaque and softened. Foreign bodies impinging on the ball or optic nerve, or lodged within the ball or orbit, should, of course, be removed, if possible.

Very little can be done medically or surgically for internal injuries of the ball. Nature is often very kind and accomplishes much. In these cases we must rely mostly on her. Muscular palsies and optic-nerve affections are treated by mercurials, strychnia, electricity, and such other remedies as the nature of the case suggests.

212 Franklin Street.

RHUS AROMATICA IN THE TREATMENT OF INCONTINENCE OF URINE.

By WILLIAM C. KRAUSS, M. D.,

Professor of Pathology in the Medical Department of Niagara University, Buffalo N. Y.

Rhus aromatica is extracted from the bark of the root of the sweet sumach, natural order anacardiaceæ, and contains a resin, volatile oil, and tannin. Shoemaker gives its physiological action as astringent, tonic, and diuretic.

Within the past two years much has been said and written of its adaptability to diseases of the genito-urinary tract, and particularly to incontinentia urinæ, enuresis. Many contributions have already appeared, among others by Max, Burvenich, Numa, Hanon, Eloy, and Powell, and all speak highly of its curative, perhaps specific, qualities in the treatment of one of the most obstinate, as well as disagreeable of infantile affections. Having been attracted by these glowing results, and having some cases at hand, I determined to test its virtues and verify for myself the praise so unstintingly bestowed upon it.

For convenience sake we may divide the etiology of enuresis into four groups.

The first group comprises slight functional disturbances of the genito-urinary tract, and produce incontinence by maintaining irritation, which causes an undue sensitiveness of the mucous lining of the bladder. As such may be mentioned, a tightened or adherent prepuce, a narrow meatus, a sensitive clitoris, a sensitive urethra,

weakness of the sphincter, cystitis, hyperacidulated urine, pressure on the bladder during pregnancy, obstipation, the presence of ascarides in the rectum, etc.

Disorders of the central nervous system very often produce incontinence in children. Precocious development or defective mental development, dreams, extreme activity of the nerve centers producing disordered sleep, and the continuance of the habit which was set up in infancy, are some of the most important of this class.

Under the third head we may group those organic diseases of the spinal cord which engender incontinence by destroying the vesical center, or by injuring the reflex arc. Diseases affecting the posterior white columns, as locomotor ataxia, transverse myelitis, spinal tumors, etc., belong to this group.

The fourth group embraces organic changes along the genito-urinary system, more especially of the bladder and its appendages. Hypertrophy of the muscular coat of the bladder as met with in women and elderly men, enlargement of the prostate, and atony of the bladder walls leading to retention and later on incontinence, are examples of this kind.

The treatment which I have formulated for these different groups is, briefly, as follows:

1st. Remove the cause of irritation, if possible, by operation or necessary treatment, and administer the fluid extract of rhus aromatica, beginning with five to ten drops, and increase to fifteen–twenty, four times daily. I generally prescribe it with glycerine, to be taken after meals and before retiring.

2d. A general nerve tonic or nerve sedative treatment auxiliary with the rhus will prove of great benefit. In anemic cases I combine the rhus with the syrup of the iodide of iron, as

R—Rhus aromatica. fl. ext. ..... ℥ v.
Syr. ferri iodidi. .....
Elixir calisaya. .....aa q. s. ad ℥ ii.
M. Sig.—One-half teaspoonful four times daily.

Incontinence of urine due to any of the causes in groups one and two yields readily to the administration of rhus aromatica.

3d. In these cases, especially in adults, where there exists organic disease of the spinal cord destroying the vesical center or its arc, rhus aromatica has had no effect whatever. I have used it in combination with the fluid extract of ergot, of each twenty drops, but have as yet been unable to discover any favorable results.

4th. Under the last head, where there is more or less hypertrophic paralysis of the vesical apparatus, I would prescribe rhus in half-drachm doses, supplemented by local treatment. I have had no experience with this group, and cannot speak knowingly.

A brief summary of my cases, with results, is here appended:

CASE I.—Female, age, 28; has been troubled with incontinence for years, all manner of treatment having heretofore been unsuccessful. The patient is of a neurotic temperament, with symptoms of neurasthenia. I prescribed rhus aromatica, twenty drops four times daily, along with a general treatment, and at the end of four weeks she considered herself cured of the incontinence. One year has now elapsed without any recurrence of the trouble.

CASE II.—Female, age, 14; has had nocturnal incontinence since childhood. She is anemic, of a nervous temperament, and presents some symptoms of exophthalmic goitre. I prescribed rhus with syrup of iron, as per formula, and at the end of five weeks the enuresis disappeared.

CASE III.—Male, age, 13; has had incontinence for the past four years. An examination revealed an adherent prepuce with accumulations of smegma. Removing the local cause and administering rhus in twenty-drop doses, along with the syrup of iron, cured the incontinence in two weeks' time.

CASE IV.—Female, age, 29; in the third month of pregnancy. For the past four weeks has complained of involuntary urination. I prescribed rhus with glycerine, and at the end of two weeks she complained of no further trouble.

CASE V.—Female, age, 6; of a highly nervous temperament; has had incontinence, nocturnal and diurnal, since birth. As a result of the long continued irritation she has had, at times, epileptic manifestations. After a thorough treatment with bromides and rhus, both epilepsy and incontinence disappeared.

CASE VI.—Female, age, 70; presents paraplegia with incontinence of urine and feces, and slight sensory disturbances, symptoms indicating a transverse myelitis. Rhus and ergot, in proportions above given, after three months' trial, were discontinued without any results.

CASE VII.—Female, age, 45; and

CASE VIII.—Male, age, 38; both suffering with symptoms of locomotor ataxia, failed to receive any benefit from the rhus treatment.

CASE IX.—Female, age, 65; has been troubled for some weeks with a girdle pain starting from the upper lumbar region, accompanied with paraplegia, incontinence of urine, and feces, and slight disorders of

sensation. The patellar reflexes at first were exaggerated, but later disappeared entirely. The onset and course of the malady points strongly to a spinal tumor in the upper lumbar region. Rhus aromatica has been given for some time without affording any relief, and was consequently suspended.

Besides the internal use of rhus aromatica, I generally advise my patients to bear in mind the following rules: Bathe the parts with cold water just before retiring. Urinate during the day as soon as a desire is present, and urinate before retiring. Eat a light lunch, and avoid all liquid foods during the evening. Enjoy good air and good morals; avoid a strict meat diet, manipulation of the parts, and undue excitement.

CONCLUSIONS.

Incontinentia urinæ due to slight disorders of the genito-urinary or nervous systems is amenable to the rhus treatment, and gives most favorable results.

Incontinentia urinæ due to destructive lesions of the spinal cord complicating the vesical center or its reflex arc, is not amenable to the rhus treatment, and gives negative results.

382 Virginia Street.

THREE CASES OF ELECTRICAL TRAUMATIC NEUROSIS.[1]

By JAMES W. PUTNAM,

Professor of Nervous Diseases, University of Buffalo.

In July, 1890, during a severe thunder and lightning storm, three telephone operators received an electric shock, from an unusually vivid flash that passed through the lightning cut-off with which the key-board is supplied. At the time of the shock each operator was wearing a metallic arrangement closely fitted to the head, which holds the receiving phone in position against the ear. They were each holding a metal plug in the hand, preparing to make a connection on the key-board.

No. 1 was a large, healthy, well-developed young woman of Irish descent, aged 20. She was rendered unconscious for a few moments. On regaining consciousness, she complained of severe headache, and of deafness of the left ear, which was in contact with

1. Read in Buffalo before the Medical Association of Central New York.

the phone, and which received the shock. Examining this patient, I found complete cutaneous anesthesia of the left side, the pharynx and conjunctivæ. There was no paralysis. From the symptoms I diagnosticated the deafness to be functional, and treated it as such by suggestion, with the result that the hearing was perfectly restored. The headache remained, and only yielded to bromide of potassium.

No. 2. A young woman of German parentage, with previous good health. She was in bed when I first visited her. She said it made her dizzy to stand up, and made her headache worse. Examination showed cutaneous anesthesia of left side of face and scalp, left side of thorax anteriorally, left arm, conjunctivæ anesthetic. The anesthesia disappeared after two treatments with the faradic brush, briskly applied. In addition she took a spinal douche, 40 degrees, 15 seconds, daily. The headache was treated with 20 grs. pot. brom. and 15 drops ergot. The headache disappeared, but always came back if she attempted work at the telephone office. Believing this to be a headache suggested to her by the sight of the apparatus from which she received the shock, I hypnotized her, and suggested that she should have no more headache, either at home or at the telephone office. She has remained well, has returned to work, and has had no return of headache.

No. 3. A slight girl, aged 21, of American parentage; was rendered unconscious for a few moments by the shock, was taken home, and was delirious for one hour, after which she became quiet; complained simply of throbbing headache. Examination discovered anesthesia, as in the others, of the left side. Sensation was restored by one application of the faradic brush; headache disappeared after a few doses of pot. brom.

The similarity of the cases at once strikes us. There was headache and anesthesia in them all, and each showed susceptibility to suggestion. I present these cases, believing them to be a combination of hysterical symptoms of anesthesia, with the headache we naturally expect to result from severe electric shock.

388 Franklin Street.

Fermentation of milk occurs only in consequence of the introduction into it of microörganisms. If the milk be received by a sterilized tube into a sterilized receptacle directly from the udder of the cow, it will not ferment or become acid, though kept indefinitely.—*Ex. in Southern Medical Record.*

Clinical Report.

A CASE OF ACUTE GENERAL PERITONITIS, TREATED BY MORPHINE IN LARGE DOSES.—RECOVERY.

By GEORGE A. HIMMELSBACH, M. D.,
House-Physician Buffalo General Hospital.

Bessie L., aged ten years, entered hospital July 15th with a history as follows: About ten days before entering indulged freely in watermelon, and at same time ate more than half of a quart of peanuts. From that time until July 21st, she had recurring attacks of pain in abdomen. On this date she was first seen by a physician, who reports as follows: Temperature, 101½°; pulse, 145; great tenderness over whole of abdomen, the slightest movement causing her to shriek from pain.

The doctor diagnosticated peritonitis, and at once put her on the saline treatment, magnesii sulphas was given in two and a half drachm doses every three hours. This, however, was only kept up for three days, when the stomach rejected the salts. Opium was then resorted to, and was given in small doses until she entered the hospital.

At time of entering, patient's abdomen was very much distended, with marked tympanites, and she was suffering excruciating pain. Temperature, 100°; pulse, 134; respiration, 24. Under Dr. Stockton's directions the child was immediately put upon the opium treatment, as recommended by Alonzo Clark. Morphine in doses of one-quarter grain each was given hypodermically as frequently as needed to keep the child in a semi-narcotized condition, and as nearly free from pain as possible. My instructions were not to allow the patient to come out from the effects of the drug, hence close observance was instituted, and just as soon as she showed evidence of this, such as flexion of thighs, restlessness, with pulse becoming slow, soft and full, the drug was repeated.

It soon became evident that the dose given was not sufficient. I accordingly gradually, but cautiously, increased the dosage until July 30th the highest point was reached, the maximum amount given in twenty-four hours being twenty-four grains, as follows: 9.00 A. M., grs. iv.; 3.00 P. M., grs. iv.; 4.30 P. M., grs. iv.; 7.40 P. M., grs. iv.; 10.30 P. M., grs. iv., and 3.40 A. M., grs. iv., all hypodermically.

It will be observed that the child had by this time attained an extraordinary tolerance for the drug, the amount which was given

at the onset of the malady and with the desired effect would, if given now, be followed by no reaction at all.

This may appear to some as very heroic and, perhaps, dangerous treatment, but it is in this very fact that the whole secret of this treatment lies. The drug must be given for its effect, regardless of the amount. It may be well to note here that at no time did the respirations fall below fifteen per minute, and ranged from this point to twenty-eight per minute.

The total amount of morphine given from July 16th to August 3d was 170 grains, all hypodermically, and the largest dose given at one time was on July 31st, grs. v. From this time on, the child showing signs of improvement, the dose was gradually reduced until gr. ¼ was reached, this being continued for a few days, and finally stopped. Ice bags were then applied, which relieved the pain greatly.

In addition to the opium, other agencies were used to relieve the distension. Hot fomentations were applied every fifteen minutes to half an hour, but with little relief. Aqua camphoræ in ʒss doses was given every half hour for some time, but without much effect.

July 20th, the tympanites became very great, and on account of the increased tension, there appeared spots of discoloration, the respirations were somewhat labored, the heart was so displaced that the apex beat could be felt in the second intercostal space; it was plain that something more radical must be done. The rectal tube was used. A soft, flexible tube was introduced with no little difficulty to the extent of three feet; it was then allowed to remain in situ for twenty-four hours, after which it was removed for twelve hours to give the parts rest. This was done alternately for periods of twelve hours, and with the happiest result.

July 26th, the tympany having disappeared, the tube was removed.

Up to July 30th, the bowels had moved but twice, and both stools were very small. On this date in palpating the abdomen, an indurated mass was felt in the left iliac region, fecal accumulation was suspected, and a mild enema, consisting of ol. terebin, ol. gossipii, and soap-suds, was given, resulting in free evacuation and disapperance of the tumor. From this time on, the child improved rapidly. Tonics, such as albuminate of iron, champagne, beef juice, were given freely to build up the much-reduced system. The patient was in condition to leave the hospital about August 20th, but owing to the unsanitary and poor hygienic surroundings

of her home, it was deemed safer to keep her under treatment and observation at the hospital for some time thereafter.

Society Proceedings.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, June 24, 1891.

The President, John B. Roberts, M. D., in the chair.

Dr. S. MacCuen Smith submitted a paper on

EMPLOYMENT OF PILOCARPINE MURIATE IN LABYRINTHINE DISEASE WITH REPORT OF CASES.

Gentlemen: Our object in calling attention to the following interesting cases is, as far as possible, to determine the diseases in which pilocarpine may be of decided benefit, and, if possible, to add to its sphere of usefulness.

Case I.—Mr. F. W., of New Jersey, 20 years of age, has been a bright scholar until within the last two years, when, on account of progressive loss of hearing, he was compelled to leave school and seek medical aid. From a critical examination of the patient, and also of his parents, the personal and family history were pronounced unusually good. The father gave positive assurance of being entirely exempt from any previous specific history, and certainly observation would substantiate his statement, as his entire family of seven children showed impressive evidence of good health.

The patient stated that he had been under treatment for three years with several specialists in neighboring cities, only to meet with discouragement, as his hearing continued to grow worse.

On examination the external ear and canal were found to be normal; membrana tympani slightly opaque and retracted, otherwise normal, except some inflammation had extended to the manubrium mallei. In the post-nasal space the pharyngeal tonsils were found to be much enlarged, the hypertrophy extending beyond and occluding each eustachian tube. Very low notes of both aërial and osseous conduction of sound were perceived in each ear—the higher notes not being heard except when intense—which would seem to prove that the internal ear was at fault; and as the voice could be heard much better than the watch-tick, this would offer additional evidence of internal ear disease. By my watch, which measures fifty inches, the hearing distance of R. E. $= \frac{1}{L}$; of L. E. = quite negative; and yet ordinary conversation from the base voice

could be heard at six feet, but individual words could not be distinguished until the sound-wave was intensified.

By removing the enlarged tonsils and post-nasal adenoid growths, the hearing power was somewhat increased by equalizing the atmospheric pressure, and this to an extent correcting the retracted condition of the membrana tympani. Knowing this patient to have been under special treatment for some time, and that the usual methods of procedure had failed to give relief, we deemed a repetition of the same to be a useless experiment, and therefore concluded to place him under the pilocarpine muriate treatment, by hypodermic injections. As the object of such treatment is to produce profuse diaphoresis, the dose to be employed must be in accordance with individual idiosyncrasy. It has been our custom to commence with a small dose, one-sixteenth to one-eighth grain, and gradually increase, until the full physiological effects of the drug are produced, provided contra-indications (*to be determined by previous careful examination*) do not manifest themselves.

The dose usually employed is one-sixth grain, although one-fourth grain is frequently necessary. In view of the danger to life that is possible to occur in administering full doses of pilocarpine, Dr. Lawrence Turnbull and other authors advise the use of atropine or strychnia in conjunction with pilocarpine. This is certainly a proper and safe precaution, and should be employed in selected cases; yet, in the greater number of cases, the writer does not find this essential.

As patients cannot usually stand the daily injection, it is our custom to administer one hypodermic once every second day; always *insisting* on the patient remaining in *bed* from three to five hours after each treatment, as the perspiration continues for that length of time, and any undue exposure or exertion may produce unfavorable symptoms. These hypodermics are continued until five, eight, or ten have been given, and then, if additional ones are required, they may be administered at intervals of five to ten days, as the symptoms indicate.

We will now relate the treatment and improvement of the case in question, the details of which are purposely given, as they are intended to express in main the general treatment and improvement of the subsequent cases; the points of difference, however, will be mentioned in each case.

February 2, 1869, we gave the above case the first hypodermic of one-eighth grain (the hearing distance, you will remember, was R. E. $\frac{1}{L}$, L. E. negative); next day patient thought tinnitus was much less

severe ; no improvement in hearing ; perspiration not profuse. February 4th, gave hypodermic of one-sixth grain, which caused copious diaphoresis, some nausea, and headache. During that evening patient heard wagons passing his window, but could not hear the music from some stringed instruments only fifteen or twenty feet away ; his hearing for conversation had materially increased ; tinnitus about the same ; watch-tick R. E. $\frac{2}{L}$, L. E. $\frac{4}{L}$. It is interesting to note the marked improvement in left ear, which up to this time had been negative.

6th. We repeated hypodermic injection of one-sixth grain, as we found this to produce full physiological effect : perspiration about the same ; absence of nausea and headache. The next day patient called and stated his hearing had never been so bad, he being unable to hear anything except very intense *high* notes ; he was, therefore, much discouraged ; all his prevous hopefulness having vanished, he refused to submit to further treatment. However, he called the following day and informed me he would continue treatment, as "he thought nothing could possibly make him worse." The peculiar effects of this last hypodermic were the almost entire loss of hearing, and the change to perceiving *only high* notes.

8th. One-sixth grain was again given, which resulted in the hearing being restored to R. E. $\frac{3}{L}$, L. E. $\frac{3}{L}$; tinnitus almost gone ; feeling much better in general health and spirits.

10th and *12th.* He received one-sixth grain, with marked improvement in hearing ; R. E. $\frac{9}{L}$, L. E. $\frac{11}{L}$; no tinnitus ; general health continues to improve.

At this date, patient's *father* called to be treated for "some fever blisters on tongue and throat," which, on examination, presented such questionable appearances that I, without hesitation, pronounced them syphilitic. He then admitted having had a chancre when twenty years old (his age at this writing being forty-nine). His excuse for previous false statements was that every physician whom his son had heretofore consulted questioned his family history, and a confession on the part of the father invariably resulted in the son being put on large increasing doses of iodide of potassium and mercury, which so impaired his health that the treatment was discontinued; and as his son had never improved under such medicament, he concluded to conceal his family history, with the hope that other methods of treatment might be pursued.

Granting that the patient's impairment of hearing was specific in origin, in view of his marked improvement I thought it wise to continue with the pilocarpine treatment, in order to more thoroughly establish its efficiency in this class of cases.

The hypodermics were continued on February 12th, and every second day thereafter until eight had been given, at which time his hearing distance was, R. E. $\frac{26}{L}$, L. E. $\frac{32}{L}$; general health improving daily; his weight has increased seven pounds; tinnitus aurium entirely gone.

21*st*. The patient returned home, feeling that he had entirely recovered; but in two weeks he called again at my office with hearing somewhat impaired—R. E. $\frac{22}{L}$, L. E. $\frac{26}{L}$—which he thought came from "catching cold," due to exposure. I again gave him three hypodermics, his hearing increasing to R. E. $\frac{36}{L}$, L. E. $\frac{39}{L}$. Additional hypodermics did not improve the hearing. Thinking he required some *specific* treatment, and remembering that iodide of potassium and mercury could not be tolerated by his stomach, I prescribed Hostelley's syrup of hydriodic acid in two-drachm doses, four times a day, well diluted in water; also inunctions of one drachm of ung. hydrarg. each night and morning. This treatment was continued for six months without experiencing any inconvenience, his hearing remaining about the same; no tinnitus; general health better than ever before, and at this writing—about fifteen months since beginning treatment—his hearing and general condition continue to be good, although the patient has not been taking any medicine for the past nine months.

Case II. Mr. S. G., of Pennsylvania, aged 71 years, consulted the writer, with his family physician, July 8, 1888, and gave the following history: On January 6th of the same year, when arising at his usual hour, he was much alarmed at not hearing the customary noise on the street; thinking, however, that his servant had by mistake awakened him at too early an hour, he consulted his watch, and, on finding the hour rather later than usual, and as everything appeared distressingly quiet, he realized that his hearing had been entirely lost during the night. This complete loss of hearing was not attended with pain, tinnitis aurium, discharge from the ears, nor inconvenience of any kind.

After being under treatment for three months, and not receiving the slightest benefit, while drinking some *hot* milk by the direction of his physician, he was seized with intense tinnitus aurium, vertigo, and constant emesis *without nausea*, but with entire absence of pain. The emesis continued for only three hours, but the tinnitus and vertigo increased in severity.

In this condition the patient consulted the writer. A more despondent and pitiable mortal could not be imagined. He was not able to walk without assistance, and the tinnitus had prevented sleep for almost two weeks. The membrana tympani and the external auditory canal

were normal, excepting the changes peculiar to a person of his years; the post-nasal space, including the Eustachian tubes, were in good condition; in brief, both ears and their appendages presented the usual normal condition in so far as observation alone could determine. In this connection it is interesting to note the entire absence of evidence of disease in such cases. Osseous conduction of sound was well marked, especially in left ear; aërial conduction of sound was quite lost in both ears.

The family physician informed me that his patient had been on large increasing doses of iodide of potassium and mercury, but the stomach would no longer retain the potassium iodide.

We subjected this patient to the pilocarpine treatment, as previously described, with the following results: First treatment resulted in slight decrease in vertigo and tinnitus, but hearing power remains the same; caused some temporary vomiting, which was quite severe for two hours. The second and third hypodermics were given without any appreciable benefit; the fourth and fifth, however, were productive of marked improvement in vertigo and tinnitus, and at the same time caused such changes in the perceptive organs of hearing that he was able to hear intense waves of sound. After the sixth treatment, tinnitus and vertigo had almost ceased, and hearing distance increased to $\frac{I}{L}$ in both ears. The seventh and eighth treatments did not produce much change in hearing distance, but entirely relieved vertigo and tinnitus. The ninth hypodermic caused much improvement in hearing: R. E. $= \frac{9}{L}$, L. E. $= \frac{11}{L}$.

The patient found it necessary to return home, and I directed his family physician to continue the treatment until four additional hypodermics had been given, at the end of which time patient called, with this marked improvement: R. E. $= \frac{21}{L}$, L. E. $= \frac{27}{L}$. The patient's business called him to the far West, and required his being away for four months. I gave him Hostelley's syrup of hydriodic acid to take during his absence. On his return the condition of hearing was almost normal, and remains the same at this writing.

As the details of a large number of such cases would consume much time and space, and withal prove tiresome, the object of this paper will have been accomplished by briefly stating that the writer has treated forty-seven cases of greater or less impairment of hearing—some amounting to almost entire deafness—by the method of hypodermic injections of pilocarpine muriate; and that from his observations in these cases he feels justified in expressing the following conclusions:

1. That age and sex have no influence on the success or failure of treatment.

2. That in recently developed deafness with tinnitus this treatment is much more hopeful of success than in cases of long duration. In one case, however, which was of specific origin, the patient, aged seventy-two years, had been almost deaf for twenty-two years, and yet this was one of the most successful cases treated. Nevertheless, this must be considered as very exceptional.

3. That cases of chronic suppurative otitis media, with some degree of impaired hearing, resulting from the exanthematous fevers, are not proper cases to receive benefit from this method of treatment.

4. That deafness, vertigo, and tinnitus, arising from syphilis, seem to be especially benefited by the subcutaneous injection of pilocarpine.

5. That these results can only be attained by pushing the pilocarpine to its full physiological effect, and that profuse diaphoresis must be obtained in every case.

HOW TO USE MYDRIATICS.[1]

By EDWARD JACKSON, M. D.,

Professor of Diseases of the Eye in the Philadelphia Polyclinic; Surgeon to Wills Eye Hospital, etc.

The present purpose is to discuss methods, not indications, for using these drugs; but, in passing, it is worth repeating, since it is so often forgotten, that remedies of this sort are too powerful to be used indiscriminately. If one has not been able to make a positive diagnosis in a case of ocular inflammation, to clearly recognize the indications, and to definitely exclude the contra-indications for one of these drugs, he should let them alone, and confine his hit-or-miss prescribing to such agents as boric acid, or weak solutions of common salt, whose power for harm is really very slight.

These drugs are applied to the eye for their direct influence on the cornea, iris, or ciliary body. In either case they must be absorbed through the cornea, the lymph streams of which are in close relation with those of the anterior chamber. Any portion of the drug that may be absorbed from other parts of the conjunctival sac is carried into the general circulation without coming in

1. Read June 24, 1891.

contact with the structures it is intended to influence. Any solution placed in the conjunctival sac is almost immediately diluted by the lachrymal secretion present; only the part with which it first comes in contact receives it of full strength. Now, if the amount of fluid instilled is very large as compared with the amount of tears diluting it, the dilution is of very little importance. But instillations of large amounts of mydriatic solutions are not advisable, because they give the maximum of absorption into the general circulation with the minimum of effect on the eye. And one thing to be constantly guarded against in the use of mydriatics is the excess of constitutional action. Therefore, a mydriatic solution used in the eye should be instilled so as to come immediately in contact with the cornea while of full strength; that is, it should be placed at the upper margin of the cornea, allowed to flow over the surface of that membrane, and the closure of the lids prevented as long as possible, to allow absorption to occur before the fluid is swept away by the movements of the lids and diluted with the tears.

Instilled in this way, the concentration of the solution when it comes in contact with the corneal tissue, and consequently the amount absorbed, may be ten times as great as if the single drop of the same solution had been placed in some other part of the conjunctival sac. Thus applied, a very small drop of solution suffices to bathe the whole cornea. A dropper giving a small drop is, therefore, to be chosen. One is readily obtained with a small point that will drop half minims, or even less. The use of such a dropper allows the employment of stronger solutions than it would otherwise be safe to employ, or a larger number of instillations may be made in the same space of time without producing symptoms of mydriatic poisoning.

It is by attention to such a minute point of technique that one surgeon will at once secure the dilatation of an inflamed iris, or the complete relaxation of the accommodation under homatropine, where another less careful will fail to attain the end sought, or to give relief to his patient. And even where the utmost power of the mydriatic does not need to be exerted to obtain the effect that is required, with the least danger of constitutional symptoms, or with the minimum of constitutional disturbance, is a very important point; for these symptoms, although really not indicating any danger to life, are extremely annoying and alarming to the patient. They occur quite frequently after the use of mydriatic solutions,

and such occurrence has much to do with the objection of patients to the use of mydriatics in the diagnosis of ametropia.

The strength of the solution of one of these drugs to be used in the eye varies with the purpose for which it is used. To break up the adhesions in a case of iritis, the stronger mydriatics are to be employed and in strong solution: As atropine sulphate, one to water fifty, or about ten grains to the fluid-ounce; daturine sulphate, one to water 100, or about five grains to the fluid-ounce; duboisine sulphate, one to water 100, or about five grains to the fluid-ounce; hyoscyamine sulphate or hydrobromate, one to water 100, or about five grains to the fluid-ounce. The effect of either of these solutions may be somewhat increased by using cocaine with it. But the patient should not be intrusted with the cocaine solution for home use, because the temporary comfort it gives, in many cases, leads sometimes to dangerous excess. Either of the above solutions is to be used one small drop in the eye at a time, at intervals of ten minutes, until the dilatation of the pupil is secured, and then at such intervals as may be necessary to maintain such dilatation; and continued three times daily until it can be replaced by a weaker solution.

In making the mydriatic attack on a case of plastic iritis, it is, to a certain extent, simply a question of whether we can get enough of the mydriatic into the eye without getting too much into the general circulation. And to accomplish this we must prevent the solution from making its way into the tear passages, and so being absorbed from the respiratory and digestive tracts, as well as from the conjunctiva. For this purpose it is often recommended to make pressure on the inner canthus. But such pressure is quite ineffective. Even the placing of a little clamp on each canaliculus, as proposed by Dr. Tansley, (*Trans. Amer. Ophthalmological Society*, 1888,) does good mainly by the displacement of the puncta that it causes. The most effective means is to so draw on the skin of the lids as to evert the puncta, and hold in contact with them a small pledget of dry absorbent cotton. This will prevent the passage of any fluid from the eye into the lachrymal sac, and permit us to apply the mydriatic vigorously to the cornea.

For paralyzing the accommodation of the eye, solutions of the same drugs of about half the above-mentioned strengths may be instilled three or four times daily.

Probably a single efficient instillation of this kind, or at most two or three, would be sufficient to produce complete paralysis of

the accommodation in almost every case, with the eye in anything like normal condition. But frequently the instillation must be intrusted to unskilled hands, and so may produce but a small fraction of its full effect, and in a few cases the active hyperemia, caused by the mydriatic and involving the anterior segment of the globe, may increase the difficulty of attaining complete ciliary paralysis; so that it may be necessary to continue such applications for some days.

For simply paralyzing the accommodation, however, our most valuable agent is homatropine, commonly used in the form of the hydrobromate. Of this a two or three per cent. solution, ten or fifteen grains to the fluid-ounce, should be instilled every five or ten minutes until at least four efficient applications have been made. Used in this way, I have found it a perfectly reliable and efficient paralyzant of the accommodation, even in the presence of high grades of retino-choroidal irritation and general hyperemia of the eye. But we have not with this drug the excess, or reserve, of power to control the ciliary muscle, that is possessed by the other mydriatics named. Every instillation, or at least a sufficient number of them, must be efficient. The cornea must have the chance of absorbing the solution at nearly its full strength; and for that reason the application of the drug must be intrusted only to skilled hands, usually attended to by the surgeon himself.

To bring about simple dilatation of the pupil, our choice of the drug will be determined by whether the dilatation is to be long sustained as a measure of treatment, or only temporary as for purposes of diagnosis. In the former case, atropine is to be used; in the latter, homatropine or cocaine. Atropine or homatropine should be employed in a solution one-tenth the strength of those used for paralyzing the accommodation, or even weaker than this. The atropine to be repeated as often as the pupil contracts again, say once every one, two, or three days; the others, of course, used only the once.

Cocaine, which is of especial value as a dilator of the pupil, is to be used in solutions of the ordinary strength ordinarily employed for producing local anesthesia of the eye, that is, two to four per cent. But the instillation must be made at least thirty minutes, often an hour, before the dilatation is desired, the anesthetic action often having quite passed away before the dilatation of the pupil becomes noticeable, and repeated instillations do not very greatly hasten this dilatation. As a paralyzant of accommo-

dation, cocaine has very little power, and by itself is not at all valuable for the purpose. But it can sometimes be advantageously combined with homatropine. Here the frequent repetitions of the instillation, as in the case of iritis, give the advantage of local anesthesia, greatly lessened resistance on the part of some patients, and prevention of the excessive secretion of tears that follows each instillation of homatropine alone, and by dilution of the solution lessens the intra-ocular effects produced, as well as an apparent hastening of absorption. For this purpose the solution may be made with two or three per cent. each of cocaine and homatropine.

The instillation of a strong solution of any of the mydriatics causes a pericorneal hyperemia, which, though not serious, is sometimes alarming to the patient or his friends. This phenomena I pointed out in a paper on homatropine, published in *The Medical News*, July 18th. It is especially liable to occur from the use of homatropine, because this is more likely to be used in stronger solutions. The combination with cocaine lessens this tendency to a considerable extent.

DISCUSSION.

Dr. T. B. Schneideman: I wish merely to call attention to the change which takes place in mydriatics when kept in solution, from the formation of a precipitate due to the growth of a fungus. I do not think that this interferes with the efficiency of the solution, although it may increase the pain. We should also remember that when we intrust the mydriatic to the hands of the patient or his friends, we often fail to get complete paralysis of the accommodation. In hospital work we often find the mydriasis disappointing on this account.

PETROLATUM.

Exhibited by Dr. John Aulde.

The subject of petrolatura was introduced into the Pharmacopeia of 1880 to cover several important products, such as cosmoline and vaseline. A considerable lack of knowledge exists in the minds of physicians in regard to the various petrolatum products. My object tonight is mainly to call attention to the appearances of these products. I have used petrolatum products largely, and have accumulated a number of specimens, which I shall present tonight. Petrolatum is extensively used for many purposes. It is largely used by

veterinarians. It is used by actresses who first apply perfectly colorless cosmoline to the face and follow it with any desired powder. After the performance, the whole is washed off with a little cologne. It has been found that the colored petrolatum products produce discoloration of the skin. Cosmoline is perfectly innocuous, and may be taken into the system without harm. Through the kindness of Mr. Drill, the superintendent of a large factory where these products are made from crude petroleum, I had an opportunity of observing the processes. I was told by the workmen that when they have a bad cold they fill the nostrils with cosmoline and the trouble is quickly relieved.

These products are obtained by fractional distillation. The first twenty per cent. is called naphtha, and embraces several substances, such as rhigolene, benzine, naphthol, etc. The next fifty per cent. that passes over is composed of illuminating oil. This leaves about thirty per cent., fifteen of which is called neutral product, and fifteen per cent. called petrolatum stock. From this last, cosmoline is manufactured. The neutral product is decolorized by filtration through bone black. It contains a certain proportion of paraffine wax. This neutral product corresponds closely to teraline, which has been extensively advertised as a remedy for consumption. The paraffine is removed by crystallization and freezing. Teraline may be of great benefit, because it contains this wax. Suppose you have a case of inflammation of the bowels with distention of the capillaries and absorption of poisonous bodies, the use of an oil containing wax would act as a local protective, as does bismuth.

Here I show you a colorless product called glycoline, alboline, and several similar names. This is an oil with the paraffine and coloring matter removed. It is made both as a liquid and as a semi-solid substance. Here is the liquid paraffine of the German Pharmacopeia, which closely corresponds with our alboline. Here I have a number of preparations of petroleum stock, varying in color from white to dark yellow. Here is crude petroleum in various forms.

Here I have a section of lung tissue prepared in the following way: It is thoroughly washed with water, then with alcohol and de-alcoholized. A mixture of oil of cloves and oil of cedar, mixed in such proportions that a glass rod introduced into the mixture shows no angular refraction, is introduced into the lung tissue, and the whole covered with paraffine wax and a little resin, and then dipped into ice water. It can then be readily cut with a knife.

DISCUSSION.

Dr. S. Solis-Cohen: I use petroleum products in two ways—one internal, and the other as a vehicle for applications to the mucous membranes. Crude petroleum is very valuable in the treatment of pulmonary complaints, especially certain stages of phthisis. It is useful combined with iodoform. Two or three grains of iodoform may be combined with an equal quantity of crude petroleum and administered in capsules. So-called alboline, or a modification of it called benzonole, is useful as a vehicle for menthol and other agents, to be applied to the respiratory mucous membrane.

Mr. Drill: There is little to be added to what has been said by Dr. Aulde. Few physicians seem to know anything about the practical preparation of these products. The idea seems to be that cosmoline is a by-product. It never was a by-product. It is really the most valuable part of the petroleum distillation. The first seventy per cent. of the distillate is worth probably five cents a gallon, while the remaining thirty per cent. is worth from twelve to twenty-five cents a gallon. The quantity of these products has greatly increased. Where pounds were used ten years ago, tons are now used, and it is sent all over the world.

Dr. Robinson: I wish to refer to a single experience with liquid cosmoline. A man came to me with acute gonorrhea, and was anxious that something be done to relieve him at once. I injected about two drachms of liquid vaseline into the urethra. The symptoms at once began to subside, and the man had a very short attack—the second and third stages being absent. I do not know that the injection had anything to do with it, but I thought it well to relate this experience.

Dr. William F. Waugh: A few years ago an effort was made in France to introduce petroleum products as vehicles for the hypodermic use of remedies. It was shown that the purified oils were innocuous, as much as a kilogramme having been injected beneath the skin of a horse at one time without causing irritation. In some respects the experiments were of value. It was shown that in this way twenty minims of purified creosote could be introduced at a single dose. If creosote is useful at all in phthisis as a germicidal remedy, the advantage of giving so large a quantity would render this method of some importance.

Dr. James Collins: I well remember the time when the first specimen of a curious oil, said to come from the earth, was brought

to the laboratory of....., who proceeded to investigate it. He obtained naphthol, paraffine, and some other products from it. He brought the subject to the attention of some friends, who asked him if he had exhausted the oil. "No," he said, "the resources of chemistry would be exhausted by this agent." This was a long time ago, and the clang and clamor of the war drove the subject from my mind. When I returned to practice I began the use of these petroleum products, and since then cosmoline and alboline have been in my office constantly. I use them in nasal and throat affections. The only use in which I have been disappointed has been in phthisis. I have tried teraline faithfully, but it has failed to fulfil the promises made for it. As an internal remedy petrolatum has not been satisfactory, and it is probable that the digestion of this hydrocarbon is not as perfect as that of some other hydrocarbons.

Dr. Aulde: I have nothing further to add except to say that I purpose preparing a paper referring to the therapeutic indications of the petrolatum products. I believe that too much has been expected of this agent. The use of these products internally should be only as an assistant to other constitutional remedies They are not absorbed, and can only do good by their local effect.

BUFFALO MEDICAL AND SURGICAL ASSOCIATION.

Reported by W. S. RENNER, M. D., Secretary.

Stated Meeting, August 4th.

The President being absent, Dr. Bartlett occupied the chair.

Dr. Irving M. Snow read a paper, entitled, Lavage and Intestinal Irrigation in the Digestive Disorders of Infants.

DISCUSSION.

Dr. Coakley does not think that the cause of the digestive disorders is always in the alimentary canal. He thinks the cause is often to be found in the state of adjacent organs. In hot climates he thinks the diarrhea, cholera infantum, and dysentery are due to the great heat. He thinks that the proper treatment is to increase the intestinal secretions, and that Dr. Snow claims too much for lavage.

Dr. Thoma related the case of a child with acute mycotic diar-

rhea which he thought might have been saved had he resorted to intestinal irrigation.

Dr. Van Peyma thought that heat affected the quality of the food ingested.

Dr. Congdon thinks that children do not require as much food in warm weather; that nature tries to free the child of the excess; and that the secretions are not supplied in abundance in hot weather. He thinks that lavage is an easy method of freeing the stomach of an excess of food.

Dr. Persons said that lavage had given him better satisfaction than any other method of treatment. It will not cure all conditions; chronic cases require more. Intestinal irrigation has also given him great satisfaction.

In treating these digestive disorders, the indications are: First, elimination; second, dietetic treatment; third, treatment of symptoms; fourth, treatment of any constitutional condition which may exist. We often do not take into consideration influences brought to bear by external circumstances. He uses antiseptics, artificial foods, and opiates when indicated.

Dr. Goltra asked if it were well, in intensely acute conditions, to wash out the stomach and intestines. He thought that then we must take into consideration the impaired condition of the blood. He believes in the use of partially digested foods.

Dr. B. G. Long thinks that by both these methods water is supplied to the system in the very acute cases. He has great faith in the use of sterilized milk.

Dr. Hayd said that the longer he employed lavage the better he liked it, and that the longer he practised medicine the less he depended upon drugs in the treatment of these conditions. Many attacks of diarrhea in children can be prevented by wearing an abdominal woolen bandage. He has not used lavage much in acute conditions; depends more on nature. He thinks the best thing for children with acute intestinal trouble is to prevent them from taking food; give them some thin gruel, barley water, or toast water.

The remedy in chronic gastritis is lavage; it carries off mucus, stimulates the stomach walls, and furthers the supply of gastric juice.

Dr. Bartlett said that he was one of the first to use injections per rectum of bichloride of mercury solution in dysentery.

For children he prefers small doses of iodide of mercury to any

other treatment. Two things he had found of importance in treating diarrhea of children. First, to take the temperature per rectum, to find out the amount of local disturbance; and, secondly, to give bromidia to quiet the child. He has never been favorably impressed by the use of prepared foods. The chief thing for the child is to get it into the country.

Dr. Snow, in reply, said he had never had any difficulty in getting parents to consent to have their child's stomach washed out. In reply to Dr. Goltra, he said that he used opiates in cholera infantum. In chronic indigestion, lavage increases the amount of hydrochloric acid, and you have added to the gastric juice what is needed without giving partially digested foods.

In reply to Dr. Long, he stated that he had mentioned that water is taken up by the stomach and intestines during the use of these methods. He held that sterilized water acted fully as well as a solution of bichloride of mercury.

Dr. Bartlett said that it had become the sad duty of the Association to take action on the death of Dr. Frank Hamilton Potter, a member of this Association, and at one time its secretary. He appointed Drs. Persons, Coakley, and B. G. Long a committee to draft resolutions. The committee presented the following

MEMORIAL.

Whereas, This Association has lost one of its most valued members in the death of its former secretary, Dr. Frank H. Potter, whose earnest zeal and untiring energy have done much to enrich the records of this Association; whose civil and professional achievements are justly recognized by his colleagues; and whose social and private life affords a noble example for emulation; therefore,

Resolved, That the Buffalo Medical and Surgical Association desires to perpetuate his memory, tenders to his bereaved family an expression of its sympathy in their loss, and directs that this preamble and resolution be spread upon its minutes.

ALBERT E. PERSONS,
J. B. COAKLEY,
B. G. LONG,
Committee.

On motion of Dr. Brecht, seconded by Dr. Hayd, the memorial was adopted as read, and it was directed that a copy of the memorial be given the family, and that it likewise be entered upon the records of this Association.

Progress in Medical Science.

SURGERY.

CONDUCTED BY

JOHN PARMENTER, M. D.

ETHER SPRAY AND COCAINE.

SCHLEICH (*Deutsche Medicinal Zeitung*, 1891, *No.* 44,) recommends the previous spraying with ether of any part in which cocaine is to be used. It must last half a minute, after which time one can employ numerous injections of cocaine—not more than 0, 01-0, 03 —cocaine being necessary to make large areas completely anesthetic. This same method is to be employed in cases where division of deeper layers is necessary, each one being treated in turn, as was the skin. In this way the author has made small resections and bone operations without giving any pain.

DESTRUCTIVE ACTION OF CARBOLIC ACID.

A. FRANKENBURGER (*Inaug.-Diss., Erlangen*, 1891,) warns against the injury to skin, and even bone, which may result from the long-continued application of weak (3, 2½, and even 2 per cent.) carbolized applications, especially upon peripheral portions of the body, such as the fingers. This effect is due in a small measure to the action of carbolic acid upon the vaso-motor system, but in the main to its destructive effect upon the red and white blood corpuscles. This induces, partly in a mechanical and partly in a chemical way, stasis, first in the capillaries, and, if the action of the drug be continued, then in the larger veins and arteries, with the result that the nutrition of the part is interfered with, and the removal of harmful substances hindered. The maceration of the epidermis caused by the acid favors evaporation, so that the gangrene is a dry one, a mummification as it were. The author believes that even weak carbolic solutions as external applications are to be either completely discarded, or to be used only with the very strictest precautions, and that the sale of carbolic water by druggists should be wholly stopped.

INDICATIONS FOR TREPHINING.

DEAVER (*Annals of Surgery*) gives the following indications for trephining:

1. Simple depressed fracture with or without brain symptoms.

2. Compound depressed fracture with or without brain symptoms.

3. Impacted fracture, simple or compound, with or without brain symptoms.

4. Comminuted fracture, simple or compound, with or without brain symptoms.

5. Compound fissured fracture, with depression of bone, without brain symptoms.

6. Compound fissured fractures, with depression of bone, with brain symptoms.

7. Compound fissured fractures, without depression of bone, and without brain symptoms, in which there is bleeding through the fissure or fissures.

8. All punctured, incised, and gunshot fractures.

TREATMENT OF PENETRATING WOUNDS OF THE ABDOMEN.

Dr. Lanphear (*Medic. Review—Internat. Journ. of Surgery*, 1891, —*July*) makes the following conclusions regarding the treatment of penetrating wounds of the abdomen:

1. All cases of penetrating gunshot wounds of the abdomen demand laparatomy; most others also require it.

2. The operation should be done immediately after the injury, if possible, so as to control bleeding before the patient is exhausted.

3. Any time within twelve hours may be regarded as the time of selection, but the lapse of many hours, or even days, need not prevent operation, since death from septicemia is likely to occur.

4. A condition of collapse is not an insurmountable contra-indication.

5. The existence of peritonitis demands, rather than forbids, an operation.

6. In gunshot wounds, Senn's hydrogen test should not be employed, as the indications are *always to operate*; perforation of the intestines is not necessary to render the wound fatal. In other penetrating wounds the test may be employed.

7. Laparatomy is, in such cases, comparatively an insignificant operation. Any surgeon of ordinary skill ought to be able to successfully operate.

8. In case of emergency, the operation here described can be made without an elaborate set of instruments. A success can be

obtained by the use of only: (*a*) a knife; (*b*) scissors; (*c*) needle and thread; (*d*) hemostatics; and (*e*) *good judgment*.

TREATMENT OF BURNS.

MONS. GRIGORESEN (*Bulletin de la Société de Biologie—Internat. Jour. of Surgery, August*, 1891,) makes the following remarks on the treatment of burns: Pure glycerine applied to the skin in the case of burns acts as an anesthetic, especially when applied early. In severe cases two or three applications should be made, so that the parts are kept constantly wet with glycerine. At first a slight burning feeling is experienced, which soon gives place to a local anesthesia somewhat resembling that produced by carbolic acid. Under this treatment the inflammation is subdued almost completely, and only a slight cicatrix is usually felt. The glycerine should be slightly rubbed in, and the parts then covered with a protective dressing.

PREVENTION OF RUST ON SURGICAL NEEDLES.

DR. DAWBARN (*N. Y. Med. Journal*) makes the following suggestions regarding the prevention of rust on surgical needles. He states that dry sterilizing of needles at the usual temperature is apt to injure their temper and cause subsequent bending during use; while boiling or steaming induces flecks of rust, and glycerine has failed. He recommends keeping the needles in alcohol after they have been treated in the following manner: The needles are immersed in benzine to remove grease, then running them through a towel the points are plunged into a piece of cork the size of a pea —to avoid dulling from jotting—and finally with their corks are placed in a wide-mouthed, glass-stoppered bottle filled with absolute alcohol. After using the needles, pass them through a thick, wet, soapy towel repeatedly, cleanse the eye with a thread, immerse in benzine, and finally replace in the alcohol. The latter substance is an efficient disinfectant, besides being an excellent protector against rust.

EFFECT OF OPERATIONS PER SE.

J. WILLIAM WHITE (*Annals of Surgery*, August and September, 1891,) in an extended article on the curative effect of operations *per se*, sums up with the following conclusions:

1. There are large numbers of cases of different grades of severity and varying character, which *seem* to be benefited by operation alone, some of them by almost any operation.

2. These cases include chiefly epilepsy, certain abdominal tumors, and peritoneal effusions and tubercle, though the improvement in the latter is, perhaps, to be explained on general principles.

3. Of the possible factors, which, by reason of their constancy, must be considered. Anesthesia seems least likely to have been effective. The other three, viz., psychical influence, relief of tension, reflex action may enter in varying degrees into the therapeutics of these cases, and taken together serve to render the occurrence of occasional cures less mysterious.

4. The theory of accident or coincidence scarcely explains the facts satisfactorily.

PISTOL-SHOT WOUNDS OF THE SKULL.

BRADFORD (*Boston Medical and Surgical Journal*, June 11, 1891,) in an article on pistol-shot wounds of the skull, makes the following *résumé:*

In penetrating pistol-shot wounds of the skull, death is to be anticipated in a large majority of cases. Recovery, however, does occur in a certain number of instances. The treatment should be the treatment of a penetrating fracture of the skull (that is, a fracture from any sharp instrument, a nail or spike). The scalp should be dissected away from the injury, and the bone thoroughly examined. Loose fragments of bone should be removed. A trephine should be used if it is considered necessary to thoroughly cleanse the wound, or to give egress to any collection of fluid or blood that may be below the dura. If the dura is penetrated, and if there is any bulging of the dura, the dural opening should be enlarged. The brain substance should be thoroughly irrigated and washed, but not probed or treated with violence. It is unnecessary to state that the strictest asepsis is desirable.

ACCORDING to a recent visitor to Japan, the people of that country pay more attention to personal cleanliness than any other people in the world. High and low bathe all over at least once a day, and sometimes oftener.— *College and Clinical Record.*

New Instruments.

NEW EAR SCISSORS.

By ALVIN A. HUBBELL, M. D., Buffalo, N. Y.
Professor of Diseases of the Eye and Ear in the Medical Department of Niagara University.

In the treatment recently of a case of congenital occlusion of the external auditory canal, I found it necessary to use some instrument whose blades would cut one-sixth to one-fourth of an inch at right angles to the axis of the canal. The cutting points of Sexton's combination forceps, etc., were tried, but they did not fully answer the purpose. I presented the difficulties under which I was laboring to Messrs. George Tiemann & Co., with some suggestions as to what I needed, and they constructed the scissors represented in the accompanying cut.

The blades are bent near the point so as to extend about one-sixth of an inch on a curve nearly at right angles to their main portions. The latter are about half an inch long. The blades are so made and adjusted as to cut cleanly in both their axial and curved parts. The handles extend backward from the blade-joint an inch and a half, and are attached by joints to a forceps spring, which is bent downward like an ordinary ear forceps, so as to be out of the line of vision when being used. The instrument is light and yet strong, and is so ingeniously constructed as to open and close in the auditory canal with perfect ease, and at the same time without obstructing a view of the parts to be reached by it in a passage not below the medium size.

These scissors have proved eminently serviceable in cutting away growths and tissues from any part of the bottom of the auditory canal. They can be used much more easily and effectively than many other instruments, and will cut both lengthwise and transversely to the canal. They have appeared so useful to me that I venture to call the attention of the profession to them.

The instrument can be obtained of the manufacturers, George Tiemann & Co., 107 Park Row, New York.

212 Franklin Street, August 1, 1891.

BUFFALO MEDICAL AND SURGICAL JOURNAL

A MONTHLY REVIEW OF MEDICINE AND SURGERY.

EDITORS:

THOMAS LOTHROP, M. D. - - WM. WARREN POTTER, M. D.

All communications, whether of a literary or business character, should be addressed to the managing editor: 284 FRANKLIN STREET, BUFFALO, N. Y.

VOL. XXXI. OCTOBER, 1891. No. 3.

THE LATE DR. FRANK H. POTTER.

THE untimely death of our late associate editor, Dr. Frank Hamilton Potter, has called forth much gratifying eulogium from the newspapers of Buffalo, as well as the medical journals throughout the country. These comments have been of such a nature as to deeply touch the hearts of the two families that have been so cruelly invaded and bereft of a son, husband, and father.

Especially has the managing editor of the JOURNAL, the father of the deceased, felt a deep and grateful sense of appreciation of the kindness manifested by his many friends throughout the country for their sympathizing words, both written and printed. He has been lifted out of a dark and dangerous despondency by these very tributes to his accomplished son, while the shower of personal letters he has also received, that have breathed tender and affectionate appreciation of both father and son, have been a tower of strength to his afflicted soul.

We feel it only an act of justice to all concerned to reprint these newspaper and journalistic articles, that they may be grouped for preservation to the memory of our lamented colleague.

T. L.

[Buffalo Morning Express, July 17, 1891.]

OBITUARY.

DEATH OF FRANK H. POTTER, M. D.

The report of the fatal illness of Dr. Frank H. Potter will prepare the public for the further announcement of his death, which occurred at his home on Franklin street at seven o'clock last evening. The blow has fallen swiftly. Early last week he was only slightly ill, and rode

out on his wheel. On Saturday last he submitted to an operation for the removal of a perityphlitic abscess. Following the operation vomiting set in, which was not controlled for thirty-six hours, and the prostration resulting carried him past recovery.

Dr. Potter was the only son of Dr. W. W. Potter, of this city, and was born at Cowlesville, Wyoming county, on January 8, 1860. He was, therefore, just past his 31st year. As a practitioner and student and teacher he stood high in his profession. He graduated from the Buffalo Medical College in 1882, having already been connected for two years with the Rochester City Hospital. In 1883 he was appointed clinical assistant to the chair of surgery in Niagara Medical College. He was also lecturer on anatomy, and had given lectures on laryngology in the same college.

He was a member of the surgical staff of the Sisters of Charity and Emergency hospitals, and was lately appointed clinical professor of laryngology in the Buffalo Medical College. He was nominated by the Council a member of the American Laryngological Association for this year. He was secretary of the section of laryngology in the American Medical Association, member of pathological and obstetric societies of the city, of the Buffalo Medical and Surgical Association, the Erie County Medical Society, and of the New York State Medical Society, besides various medical clubs.

On June 11, 1887, he married Eva daughter of Mr. L. G. Sellstedt, who survives him, together with two sons, one three years and the other four months old. All who knew Dr. Potter will regret his early death. Whether as physician, teacher, or friend, he was a man greatly esteemed and beloved, and he will be deeply missed both by the profession and the community.

The funeral will take place from the residence of Dr. W. W. Potter, No. 284 Franklin street, at 3.30 o'clock tomorrow afternoon.

[Buffalo Courier, Friday, July 17, 1891.]

OBITUARY.

DR. FRANK HAMILTON POTTER.

Dr. Frank Hamilton Potter, of No. 273 Franklin street, died at 7 o'clock last night, after an illness of ten days' duration.

He was the only son of Dr. William Warren Potter, of No. 284 Franklin street, and was born in Cowlesville, Wyoming county, January 8 1860, being in his 32d year at the time of his death. In 1882, when he was 22 years of age, he was graduated from the Buffalo Medical College. Prior to this time he had served as resident physician in the Rochester City Hospital for two years. In 1883, at the organization of the Niagara University, he was appointed clinical assistant to the chair

of surgery, and subsequently held the position of lecturer in anatomy and laryngology. He at one time was a member of the surgical staff of the Sisters of Charity and Emergency hospitals. He first began the practice of general medicine, which he continued for a time, but afterward gave it up for the special field of laryngology, for which he had fitted himself in the schools of both this country and Europe. But recently he was appointed clinical professor of laryngology of the University of Buffalo. He was also associate editor of the BUFFALO MEDICAL AND SURGICAL JOURNAL with his father. He was a member of numerous medical societies, among which were the Buffalo Medical and Surgical Association, Erie County Medical Society, Medical Society of the State of New York, Buffalo Pathological Society, and Obstetrical Society. He was also a member ot the Saturn and Thursday clubs. During the year 1890 he was secretary of the laryngological section of the American Medical Association, and he was recently chosen by the Council of the American Laryngological Association for membership in that organization.

In political life he had taken a small part, having served two terms as civil service commissioner. He was removed from that office by Mayor Becker along with Mr. Loomis, but was re-instated when Mayor Bishop was elected. This office he resigned about a year ago on account of other business duties.

In 1887 he was married to Eva, daughter of Lars G. Sellstedt. To them two children were born, both of whom, with his wife, survive him. He was an active and hard-working member of his profession, and had until recently enjoyed the best of health. A week ago last Sunday he was taken ill, but was not compelled to take to his bed until Wednesday. It was then found that he was suffering from an enlargement of one side of the abdomen. On Saturday a surgical operation was performed, at which time nearly six ounces of pus were taken from the region of the colon. Blood poisoning had set in, and he failed rapidly, dying last night.

The funeral will be held on Saturday afternoon at 3 o'clock.

[Editorial in the Courier, July 17th.]

THE LATE DR. F. H. POTTER.

The death of Dr. Frank H. Potter deprives the community not only of a skilled physician, who gave every promise of achieving eminence in a special branch of his profession, but also, which makes his loss even more lamentable, of a man who stood as the type of a good citizen. For, in spite of his professional ability and enthusiasm, he was unwilling to sink the man in the physician. He took a zealous interest in public affairs, and was ready to give time and labor to the advancement of reforms, not as a partisan, but as a lover of good government and

progressive politics. He cultivated every side of a well-rounded nature. He had a fine literary taste, and enjoyed the more elevated forms of verse and prose. He had a clear understanding of mechanical principles, and keenly appreciated the relative merits of rival forms of machinery. He was a delightful associate, interested in all subjects, and well informed in most, with a delicate sense of the humorous and picturesque in life, and withal of a singularly modest, gentle, and pure character. Those who knew Dr. Potter at all, liked him, and those who knew him best loved him.

[Buffalo Commercial, Friday July 17 1891.]

DEATH OF FRANK H. POTTER.

THE YOUNG PHYSICIAN PASSED AWAY LAST EVENING.—SKETCH OF HIS LIFE.

Dr. Frank Hamilton Potter died at 7 o'clock last evening at his residence, No. 273 Franklin street, of the peculiar disease known as appendicitis, which resulted in blood poisoning. As stated in the *Commercial*, an abscess caused by the lodging of a seed or other foreign substance in the little sac known as the vermiform appendix. An operation was recently performed, but blood poisoning had already taken place, and he sank rapidly. It was known yesterday that he could not live. "He cannot live through the day," was the word from Dr. Parmenter, who remained with him almost constantly during the last days of his life. Towards evening there was a slight rally in the condition of the patient, raising a feeble hope, but it proved to be only a flicker of the light before darkness came.

Dr. Potter was one of the best known of the younger physicians of this city, and also one of the best liked. He was the sort of a man who would be picked out instinctively as one who could be trusted, who would be a true friend. That judgment would have been correct.

He was born on January 8, 1860, in Cowlesville, Wyoming county, and was the only son of Dr. William W. Potter, now of No. 284 Franklin street, this city. He graduated from the Buffalo Medical College in 1882, when but 22 years of age. By this time he was well schooled in his profession, as he had already served as resident physician in the Rochester City Hospital for two years. When Niagara University was organized, in 1883, Dr. Potter was appointed clinical assistant to the chair of surgery, and later on took the position of lecturer in anatomy and laryngology. He soon forsook general practice to make a specialty of throat diseases. He was very skilful in his specialty, having devoted much study to it in this country and Europe. His skill in this particular received fitting acknowledgment quite recently when he was appointed clinical professor of laryngology at the University of Buffalo.

Some years ago he was on the surgical staff of the Emergency and Sisters' hospitals. He was a writer of considerable ability, as demonstrated by his work as associate editor with his father, of the BUFFALO MEDICAL AND SURGICAL JOURNAL. He was a member of the Buffalo Medical and Surgical Association, Erie County Medical Society, Medical Society of the State of New York, Buffalo Pathological Society, and Obstetrical Society. During 1890 he was secretary of the laryngological section of the American Medical Association, and was recently chosen by the Council for membership in the American Laryngological Association. The social and literary side of his character found expression in the Saturn and Thursday clubs, in which he held membership.

Dr. Potter served two terms as civil service commissioner. He resigned the office about a year ago. He was married in 1887 to Eva Sellstedt, daughter of L. G. Sellstedt, the well-known artist. His wife and two children survive him.

[The Buffalo Commercial, July 18th]

DR. POTTER'S FUNERAL.

The funeral of the late Dr. Frank Hamilton Potter was held this afternoon at 3.30, at the residence of his father, 284 Franklin street. The services were conducted by the Rev. Mr. Ferguson, rector of St. James' Church, Syracuse, and Rev. H. G. Lord, pastor of the West-Side Presbyterian Church. After the services were concluded, the body was taken to the Buffalo crematory for incineration, The bearers were: Dr. James W. Putnam, Dr. John Parmenter, Dr. John O. Roe, Mr. Seward A. Simons, Mr. E. R. Rice, Mr. F. F. Williams, Mr. Carlton Sprague, Mr. F. J. Shepard.

[The Buffalo Commercial editorial column.]

The death of Dr. Frank Hamilton Potter, of this city, at the early age of 31, is a very grievous affliction to his friends, and a real loss to the community. He was a well-educated physician, with a growing fame and practice. He was a companionable man, of varied tastes and sympathies, as the active part he took in public affairs and in literary and social clubs testified. His future seemed as bright and promising as that of any of the younger professional men in Buffalo. His taking-off seems untimely; but perhaps it is wiser to regard it as the passing on to an earlier fulfillment of the promise of his youthful excellence.

Editorial in the Times, Friday evening, July 17, 1891.]

The *Times* said in its editorial columns:

. . . . . .

Dr. Potter was a surgeon of unusual skill in his special line of work, and active in social clubs and orders. He had written much on

professional subjects, and took an unusually active interest in public affairs. The deepest sorrow will be felt by all who knew him, that one whose life was so full of promise for good should be called away at the very threshold of a distinguished career.

[The Times, Saturday evening, July 18, 1891.]

IN MEMORY OF DR. POTTER.

TRIBUTES PAID BY MEMBERS OF THE PROFESSION IN BUFFALO.

Resolutions of respect to the memory of the late Frank H. Potter were passed yesterday afternoon by the faculties of the Niagara and Buffalo medical colleges. A special meeting of the Erie County Medical Society was held in the evening, and a committee consisting of Drs. Bartlett, Abbott, and Rochester submitted the following resolutions, which were adopted:

[These resolutions appear on page 42, August number of the JOURNAL.]

Remarks were made by Drs. Parmenter, Snow, Clark, Putnam, Howe, Cronyn, Ingraham, Pryor, Hubbell, Abbott, and Rochester. The time of the funeral has been changed to 3.30 o'clock this afternoon.

[The Times, Friday evening, July 17, 1891.]

DEATH OF DR. POTTER.

HE SUCCUMBS LAST EVENING AFTER A BRIEF ILLNESS.

Dr. Frank Hamilton Potter died at 7 o'clock last evening, at his residence, No. 273 Franklin street, after a ten days' illness.

The news of Dr. Potter's death will be heard with sincere regret by many friends at home and abroad. His illness was known to but a few. Early last week he was slightly indisposed, but still took pleasure in riding out on his wheel. On Saturday it became necessary to perform a surgical operation on him for the removal of a perityphlitic abscess in the region of the head of the colon. About six ounces of pus was removed. Vomiting followed the operation which could not be controlled for thirty-six hours. The resulting prostration, coupled with septicemia, brought about a rapidly fatal termination.

Dr. Potter was the only son of Dr. W. W. Potter, of this city, and was born January 8, 1860, at Cowlesville, Wyoming county. He graduated from the Buffalo Medical College in 1882, and engaged in the practice of general medicine.

Later he prepared himself for the special field of laryngology, both in this country and Europe, and thereafter devoted his entire attention to this specialty. During his medical career he held at various times the positions of clinical assistant to the chair of surgery, lecturer on anatomy, and lecturer on laryngology in the Niagara Medical College. He was at one time a member of the surgical staff of the Sisters of Charity

and Emergency hospitals, and had just recently been appointed to the chair of Professor of Laryngology in the Buffalo Medical College. He was associate editor of the BUFFALO MEDICAL AND SURGICAL JOURNAL, a member of the State Medical Society, ex-secretary of the laryngological section of the American Association, and a member of all the local medical societies and other organizations. He also held the office of civil service commissioner for two terms, resigning about a year ago owing to increasing professional business.

In 1887 he married Eva, daughter of Mr. L. G. Sellstedt, who survives him with two sons, one three years and the other four months old.

Dr. Potter was greatly esteemed by all who knew him, either in his professional or private life, and numbered many people at home or abroad among his friends. The funeral will take place from the residence of his father, No. 284 Franklin street, at 3.30 tomorrow afternoon.

[The Illustrated Buffalo Express, Sunday, July 26, 1891.]

(With Portrait.)

FRANK HAMILTON POTTER, M. D.

AN ABLE YOUNG PHYSICIAN WHOSE DEATH IS DEEPLY MOURNED.

The sudden death of such a man as the late Dr. Frank Hamilton Potter, of this city, which occurred July 16th, in his 32d year, a man whose earlier student life already showed abundant fruits in practice, has brought anguish to his family, deep sorrow to his friends, and genuine regret to those that knew him even slightly.

Dr. Potter was born at Cowlesville, Wyoming county, New York, January 8, 1860, and was the only son of Dr. William Warren Potter, also a prominent member of the medical profession, residing in Buffalo.

The younger Dr. Potter graduated from the Buffalo Medical College in 1882, after having received academical training to fit him for his professional work. Prior to his graduation he served two years as resident physician in the Rochester City Hospital. He was engaged in general practice for several years, during which he served as assistant to the chair of surgery in the Niagara Medical College, as lecturer on anatomy, and, finally, after adopting laryngology as his specialty, he was appointed lecturer on diseases of the nose and throat in that college. He served also as a member of the surgical staff of the Sisters of Charity and the Emergency hospitals. In 1889 he was elected secretary of the laryngological section of the American Medical Association, and lately had been chosen by the Council for membership in the American Laryngological Association. Very recently the faculty of the Medical Department of the University of Buffalo elected him as clinical professor of laryngology in that institution. All these honors attest his general and special acquirements in his chosen field.

He was twice appointed civil service commissioner, resigning in the midst of his second term because of the increase of professional cares. But he was always ready to give of his time and strength to the duties of the citizen. His was not a one-sided development. He was active socially, as a member of the Saturn Club, and was one of the twenty-five members of the Thursday Club, a purely literary society.

No man who has worked thus, even though cut off untimely, has been here in vain. His influence in the community was good, and shall not cease. To his friends he has left a high example, and to those dearer ones a sweet, inspiring memory.

In June, 1887, he married Eva, daughter of Mr. L. G. Sellstedt, the well-known artist of this city, and his widow and two children, one three years and the other four months old, survive him.

[From the St. Louis Medical Mirror, Aug. 1, 1891.]

DR. FRANK HAMILTON POTTER.

It is with extreme sorrow that we learn of the death of Dr. Frank Hamilton Potter, the only son of a devoted father, —and how much is expressed in that sentence? The only son of a doctor, who has been so favorably impressed with the profession of medicine by the example of his father as to desire to follow in his footsteps. Fully alive to the burdens and cares and sorrows and heart-burnings that are connected with the practice of medicine, he must needs be a young man of nerve, must have indeed been impressed favorably by his association with his father, —his partner and chum—in order for him to have been willing to assume the duties connected with the profession for life: but just such a person was Dr. Frank Potter. Not many years' difference between the ages of the two, —just enough to be compatible with the proper laws of physiological reproduction – the two men were all the world to each other. The eminence achieved by Dr. William Warren Potter, the father, served as a stimulus to the son. He worked, and he won, and he achieved a very enviable position in his profession. Not only that, but for one so young, he must have been more than an ordinary man, in his relations to his native place as a citizen. The Buffalo papers were filled with column after column of eulogium referring to his work as a physician, to his sterling integrity as a man, and to his value as a progressive citizen. Hardly an interest in Buffalo but that mourned the death of Dr. Potter. Young and ambitious, full of honors already achieved, what a brilliant future was before him: and yet, in the harness, in the midst of his work taken down suddenly with an obscure trouble which soon developed the necessity of abdominal section, – a suppurating appendicitis was discovered but too late, and a fatal septic peritonitis carried him away.

The young family of Dr. Potter are left to mourn him, – how deeply,

can never be told.—but the other family, the elder ones, how great is their sorrow, too! A doting mother, proud of her boy; a strong, able, manly father, still young in years, and ambitious for himself, but more ambitious for his boy, are left almost like shipwrecked sailors. Our hearts go out to them in deepest sorrow. We think of our own boy of four years, one of the idols of our life now, as we look way down the vista of the future, and as the possibilities of such a record come before us, we could feign turn aside and say to ourselves, "Is life worth living?" And yet we believe it is worth living. It is worth living for the work there is in it; and Dr. Potter, Sr., must needs keep his face to the front and his hand to the plow and work, because after all that is the greatest solace in sorrow. He can rest assured that he has the sympathy of the medical profession of the United States.

[The Times and Register, Philadelphia, August 1, 1891.]

Dr. Frank H. Potter, only son of Dr. William Warren Potter, of Buffalo, died July 16th, of appendicitis. An operation had been performed, but blood-poisoning set in.

Dr. Potter was but thirty-one years of age, but had already established his reputation as one of the rising men of his profession. At the time of his death he was clinical professor of laryngology in the University of Buffalo, and was associated with his father in the editorship of one of our most valued exchanges—the BUFFALO MEDICAL AND SURGICAL JOURNAL.

We tender our sincere sympathy to his family in their bereavement.

[The Canadian Practitioner, Toronto, August 1st.]

Dr. Frank H. Potter, of Buffalo, only son of Dr. W. W. Potter, of the same city, died at his home, July 16th, after an illness of about twelve days, from pericecal abscess. A section was made by Dr. Mordecai Price, of Philadelphia, and about six to eight ounces of pus evacuated. The prospects were good for a time, but he commenced to sink after the fourth day of operation, and death occurred on the following day. He was a young man, *act.* 31, of unusual promise and most lovable disposition, and his untimely death was a sad blow to his relatives and many friends.

[The Cincinnati Lancet-Clinic, August 22, 1891.]

OBITUARY.

THE LATE DR. FRANK HAMILTON POTTER.

The medical press is seldom called upon to record a more melancholy and untimely death than that of Dr. Frank Hamilton Potter, which

occurred at Buffalo, N. Y., July 16, 1891. Dr. Potter was a young man—not yet thirty-two—but the son and grandson of distinguished physicians. He entered the profession with endowments that speedily gave him recognition and position among the most distinguished of his confrères. After a preliminary education, he became a student in the medical department of the University of Buffalo, from which he received the Doctorate in 1882. It was at once apparent that in graduating, he had received not only his diploma, but that with it he had received inspiration from the spirits of Austin Flint, Sr., and Charles A. Lee, and Frank Hamilton, and Miner, and others, who, as founders and teachers, had brought fame to his *alma mater*. Within a year afterwards he was elected associate to the chair of surgery in the then recently organized Medical Department of Niagara University, in which school he subsequently and successfully taught anatomy and laryngology, the latter in recent years being his chosen field of practice. But a few months prior to his death he had been invited to, and had accepted the chair of laryngology in the Medical Department of the Buffalo University. He was a member of local and national medical societies, the latter embracing the American Medical and American Laryngological Associations. He was secretary of the Section on Laryngology and Otology of the American Medical Association at Nashville in 1890.

The following list of contributions from his pen shows how enormously he had tilled the field of professional knowledge:

The Proper Use of Ergot in Obstetrical Practice, B. M. & S. J., 1886-8, xxvi., 55-64.

Some General Rules which will Determine the Necessity of an Operation in the Nasal Passages, B. M. & S. J., 1886-7, xxvi., 443-447.

A Curious Effect of Cocaine, B. M. & S. J., 1887-8, xxvii., 210-212.

Tuberculosis of the Nose, Mouth and Pharynx, B. M. & S. J., 1887-8, xxvii., 295-303.

The Galvano-Cautery in the Treatment of Enlarged Tonsils, *Med. News*, Philadelphia, 1888, 255-257.

Notes on the Treatment of Acute Tonsilitis in Children, B. M. & S. J., 87-8, xxvii., 455-458.

Report of a Case of Congenital Bony Occlusion of the Anterior Nares, B. M. & S. J., 1888-9, xxviii., 74-96.

Notes on the Treatment of Acute Coryza, B. M. & S. J., 1888-9, xxviii., 302-307.

The Galvano-Cautery in the Treatment of Enlarged Tonsils, *Trans. Med. Soc. N. Y.*, 1888, 392-397.

Membranous Rhinitis, *Jour. Laryngol.*, London, 1889, III., 89-92.

A Mechanical Nasal Saw, B. M. & S. J., 1888-9, xxviii., 671.

Membranous Rhinitis, *Trans. Med. Soc. N. Y.*, Philadelphia, 1889, 222-228.

The Influence of Oral Irritation in the Production of Diseases of the Upper Air Tract, B. M. & S. J., 1889-90, xxix., 12-17.

The Use of Menthol in Diseases of the Upper Air Passages, *Jour. Amer. Med. Asso.*, Chicago, 1890, xiv., 147-149.

Reflex Asthma Especially of Nasal Origin, B. M. & S. J., 1889-90, xxix., 463-468.

Notes on Nasal Hemorrhage, *Jour. Amer. Med. Asso.*, Chicago, 1890, xv., 467.

Neurasthenia and Nasal Disease, B. M. & S. J., 1890-91, xxx., 337-415.

A Second Note on Croupous Rhinitis, B. M. & S. J., 1890-91, xxx., 525-527.

Dr. Potter leaves a distinguished father, Dr. William Warren Potter, to mourn his loss, and with him mother, sisters, wife and children. The balm that may assuage their grief must be found in reflecting upon his achievements, and upon the reward which he earned in his brief life.

[The Cincinnati Medical Journal, August, 1891.]

DR. FRANK HAMILTON POTTER.

We regret to be compelled to announce the death of Dr. Potter, as with it the profession loses one of its most able, conscientious and successful workers, and his place both in literature and practice will with difficulty be filled.

Dr. Potter was the only son and eldest child of Dr. Wm. Warren Potter, managing editor of the Buffalo Medical and Surgical Journal, and was associated with his father in the editorial management of this valuable publication.

He was born in Cowlesville, N. Y., January 8, 1860, and died July 16, 1891.

He graduated from the Buffalo Medical College in the class of 1882, at the early age of 22. Prior to his graduation he served in the Rochester City Hospital for two years.

He held the lectureship of descriptive anatomy and clinical assistant in Surgery in the Niagara University in 1883-4, and lecturer on botany in 1884-5, lecturer on materia medica from 1885 to 1888, and lecturer on laryngology from May, 1888, to 1891. In recognition of his efforts this University conferred upon him the *ad eundum* degree of M. D.

At the close of the session 1891, he severed his connection with this school and accepted the chair of clinical professor of laryngology in the Buffalo University Medical College.

A more fitting tribute cannot be paid to his memory than that of the

BUFFALO MEDICAL AND SURGICAL JOURNAL, when it says: "The profession join in the general sorrow pervading the community, and tender their sincere sympathy to the afflicted families for this strange dispensation which robs them of a devoted son and brother, a loving husband and father, and the city of a respected and honored citizen."

[From the Nashville Journal of Medicine and Surgery, August, 1891.

We note, with extreme regret, the death of Dr. Frank H. Potter, of Buffalo, N. Y., at the age of 31. To Dr. William Warren Potter, his honored father, one of the editors of the BUFFALO MEDICAL AND SURGICAL JOURNAL, we extend our heartfelt sympathy.

[St. Joseph (Mo.) Medical Herald.]

THE DEATH OF DR. FRANK H. POTTER.

The August number of the THE BUFFALO MEDICAL AND SURGICAL JOURNAL contains a notice of the death of this brilliant and promising young man, who gave evidence of a successful future. Already had he attained a high rank in his profession, and needed but time to make his mark among men. The loss of a promising child at any age is a severe affliction, which only those who have suffered a like loss can possibly appreciate or know the depth of sorrow and grief that overwhelm the heart of the parent; but when that child is a man, with a bright future before him, one who has shown the world what were his capabilities, the loss becomes oppressive and bears down the heart in the deepest suffering. But there is some alleviation of the parents' grief in the reflection and assurance that they have the sincere sympathy of the profession throughout the land. The editors of the *Herald* join in the expression, and offer to the bereaved their sincere condolence.

[From the Richmond (Va.) Practice, July, 1891.]

DR. FRANK HAMILTON POTTER

The associate editor of the BUFFALO MEDICAL AND SURGICAL JOURNAL, and son of Dr. William W. Potter, of Buffalo, N. Y., died July 16th, after a short illness. He was a frequent contributor to medical literature. Personally, he was a most genial and courteous gentleman. Our sincere sympathy is extended to his bereaved family.

[From the North Carolina Medical Journal, July, 1891.]

Dr. Frank Hamilton Potter, of Buffalo, died on the 16th inst., as we learn from the *New York Medical Journal*. He was the son of Dr. William Warren Potter, editor of the BUFFALO MEDICAL JOURNAL, and was associated with his father in the editorship of that journal. Dr. Potter has our profound sympathy in his affliction.

[From the Alabama Medical and Surgical Age, August, 1891.]

FRANK HAMILTON POTTER, M. D.

The sudden death of such a man as the late Dr. Frank Hamilton Potter, of Buffalo, N. Y., which occurred July 16th, in his 32d year, a man whose earlier student life already showed abundant fruits in practice, has brought anguish to his family, deep sorrow to his friends, and genuine regret to those that knew him even slightly.

Dr. Potter was born at Cowlesville, Wyoming county, New York, January 8, 1860, and was the only son of Dr. William Warren Potter, also a prominent member of the medical profession, residing in Buffalo.

The younger Dr. Potter graduated from the Buffalo Medical College in 1882, after having received academical training to fit him for his professional work. Prior to his graduation he served two years as resident physician in the Rochester City Hospital. He was engaged in general practice for several years, during which he served as assistant to the chair of surgery in Niagara Medical College, as lecturer on anatomy, and, finally, after adopting laryngology as his specialty, he was appointed lecturer on diseases of the nose and throat in that college. He served also as a member of the surgical staff of the Sisters of Charity and the Emergency hospitals. In 1889 he was elected secretary of the laryngological section of the American Medical Association, and lately had been chosen by the council for membership in the American Laryngological Association. Very recently the faculty of the medical department of the University of Buffalo elected him as clinical professor of laryngology in that institution. All these honors attest his general and special acquirements in his chosen field. He was twice appointed civil service commissioner, resigning in the midst of his second term because of the increase of professional cares. But he was always ready to give of his time and strength to the duties of the citizen. His was not a one-sided development. He was active, socially, as a member of the Saturn Club, and was one of the twenty-five members of the Thursday Club, a purely literary society.

No man who has worked thus, even though cut off untimely, has been here in vain. His influence in the community was good, and shall not cease. To his friends he has left a high example, and to those dearer ones a sweet, inspiring memory.

In June, 1887, he married Eva, daughter of Mr. L. G. Sellstedt, the well-known artist of Buffalo, and his widow and two children, one three years and the other four months old, survive him

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ACTION OF THE AMERICAN LARYNGOLOGICAL ASSOCIATION.

The American Laryngological Association, at its August meeting, held in Washington, September 22 to 24, 1891, adopted the following memorial:

Resolved, That this association, recognizing the high intellectual and professional attainments of Dr. Frank H. Potter, deeply deplores that so

bright a light should be put out at the very threshold of his professional career, and on the eve of his admission to this Society. That it tenders to his family its sincere sympathy in their bereavement, and mourns the loss with more than ordinary feelings of sorrow.

ACTION OF THE CIVIL SERVICE REFORM ASSOCIATION.

The following resolution was adopted at a meeting of the executive committee of the Civil Service Reform Association, held September 8, 1891:

By the death of Dr. Frank H. Potter the Civil Service Reform Association of Buffalo loses from its executive committee an interested and active worker. His arduous service, without compensation, as a member of the municipal civil service commission, showed that as a physician he was keen to discern the causes of disease even in the body politic, and fearless in applying the needful remedies. Ashamed to satisfy his conscience with passive approval of what was good, or passive condemnation of what was bad, he gave to his city in full measure the energy and the intelligence which always characterized him. The city of Buffalo can ill afford to lose from its service, at the beginning of his usefulness, a citizen of such high mental and moral worth, and so unselfishly and actively interested in the cause of purer government.

FREDERIC ALMY,
Secretary.

THE SHEPPARD HOSPITAL FOR THE INSANE.

THIS beneficent charity, erected by the liberality of one man, a public-spirited citizen of Baltimore, whose name it bears, is now nearly ready for the reception of patients. Dr. Edward N. Brush, a former resident of Buffalo, and for several years editor of this journal, has been chosen Superintendent. Last May a reception to the medical superintendents of insane hospitals in this country, and their friends, was given by the Board of Trustees, and we extract the following account thereof from the *Baltimore American* of May 2, 1891:

A special train, made up of eight coaches, left North avenue Station, on the Maryland Central Railroad, at 1.45 P. M. yesterday, for the Sheppard Asylum. On board were members of the Association of Superintendents of American Institutions for the Insane, and prominent citizens of Baltimore, who had been invited by the trustees to visit the Sheppard Asylum. Upon the arrival of the visitors at the asylum, luncheon was served.

Afterwards the visitors were addressed by Mr. George A. Pope, President of the Board of Trustees, who said the trustees had availed of the occasion of the meeting at Washington, D. C., of the annual convention of medical superintendents of the institutions for the insane of the United States,

to invite its members to visit and inspect our work done at the Sheppard. Mr. Pope then gave a graphic account of the founding, plan and purpose of the institution. "With a few months' more work," he said, "on the water-fixtures, electric lights, mantels, interior furnishings, etc., the trustees expect to be ready to receive patients in the autumn of this year. They esteem the institution especially fortunate in having secured the services of Dr. Edward N. Brush as its medical superintendent. We present to you today merely the shell, the opportunity, of what may develop into a great curative establishment. You will see that much is yet to be done in furnishing and adornments inside, and in indispensable embellishments outside, such as walks, arbors, fountains, conservatories, flower and fruit gardens, lawns, pavilions for amusements, etc., and that our limited income will necessitate all this to be done gradually, and that to accomplish the approximate perfection we aim at, we shall require adequate compensation for the conveniences and facilities we can offer patients who can afford to pay for them, in order that we may be able to extend its advantages to some of slender means. It is by no means the intent to confine its resources for cures to the rich, but that the unfortunates who may be wealthy may help their poorer brethren"

CONTRASTING THE PRESENT WITH THE PAST.

Dr. Edward N. Brush, of Philadelphia, the medical superintendent-elect of the Sheppard Asylum, then spoke, saying among other things: "It may not be generally known, but the sum left by Moses Sheppard, and the institution and grounds which have been provided therefrom, represent a larger amount than has ever been contributed by any individual in this country for the care of the insane. The State of Maryland has, therefore, the proud distinction of possessing the only institution in the United States for the insane founded by the charity of one individual. In Europe a few such exist, but I have learned of but two or three. One, the Crichton Royal Asylum, Dumfries, erected by Mrs. Crichton to the memory of her husband. The foundation fund, £120,000, represents almost exactly the sum left by Moses Sheppard. It was not until a little more than ten years before Moses Sheppard took the first steps toward founding this institution that chains and shackles were removed from the insane of England. I dare say there are some here who can recall the asylums of fifty years ago. Let him contrast them with these wards, even in their present state, and then imagine carpets, fixtures, books, furniture, flowers, and singing birds, and he will exclaim: "Truly, the gospel of the care of the insane today is that of sweetness and light."

I can say nothing which will better show what an institution of this kind should be than to quote from Conolly's concluding words in his "Construction and Government of Asylums." He says:

"I hope my concluding words will be believed when I say that if the whole of the system which I have endeavored imperfectly to sketch be steadily persevered in,—no anger, no severity, no revenge, no deception, no disregard ever shown to the insane,—calmness will come, hope will revive, satisfaction will prevail. Some unmanageable tempers, some violent or sul-

len patients there must always be, but much of the violence, much of the ill-humor, almost all the disposition to meditate mischievous or fatal revenge or self-destruction, will disappear. Some of the worst habits that beset the poor lunatic will also be got the better of; cleanliness and decency will be maintained or restored; and despair itself will sometimes be found to give place to cheerfulness or secure tranquility. Constant intercourse and constant kindness can alone obtain their entire confidence; and this confidence is the very keystone of all successful management."

Since that was written, medicine has taken enormous strides, but nothing today in the medical and general care of the insane remains which is not covered and included by these few lines. Such be our guiding principle. When these doors, a few weeks hence, are opened for the reception of patients, will begin the real work of the asylum. To relieve, to restore, to protect, to tenderly care for the unfortunates who are brought to our doors, will then be our duty and privilege. Let us hope to establish here at once an hospital and an asylum, for I believe the functions of an institution of this character are two-fold—to restore to his home and friends, if possible, the victim of insanity; if not, to afford him an asylum and refuge, a protection for himself and the world.

The other speakers were: Dr. Daniel Clarke, of Toronto; Dr. H. P. Stearns, of Hartford, Conn., and Dr. J. B. Chapin, of Philadelphia.

STATE MEDICAL EXAMINING AND LICENSING BOARD.

The first meeting of this important body was held in the Lieutenant-Governor's Chamber, in the State Capitol, at Albany, September 1, 1891.

The meeting was called to order by the temporary chairman Dr. W. C. Wey, of Elmira. A ballot having been ordered, Dr. Wm. Warren Potter, of Buffalo, was elected president; Dr. Potter declined the office for personal reasons, whereupon Dr. W. C. Wey was elected President, and M. J. Lewi, of Albany, was elected Secretary. The board then took a recess to attend a conference of the joint boards of medical examiners, and on re-assembling ratified the following recommendations to the Board of Regents:

1. A medical syllabus to be prepared (covering all subjects in which examinations are to be held) under the direction and supervision of a committee of six, to consist of two members appointed from each board.

2. A committee on questions composed of six members, two to be appointed from and by each board, whose duty it shall be on the call of the Secretary of the State Board of Regents, to convene

at Albany and revise all questions submitted by the individual examiners under section five of the law.

3. Each question paper on the seven topics shall consist of fifteen questions, of which the candidate shall cancel five, and shall be marked on his answers to the remaining ten.

4. One hundred points shall be the standard, and each candidate must secure seventy-five points in every branch before his or her name shall be recommended to the Regents as a proper person to be licensed to practice medicine in the State.

5. Four examinations shall be held during the coming year, the dates of which may be fixed at the discretion of the Board of Regents.

6. All examinations shall be conducted in the English language.

7. Examinations for medical license shall be conducted in all subjects at one continuous session.

8. No conference of the Boards of Medical Examiners shall be held, excepting on request of a joint call by a majority of the members of at least two of said boards, as certified to the Secretary of the Board of Regents by the proper officers.

9. If, in the opinion of the Board of Regents, it becomes necessary or advisable, additional examinations shall be called as occasion may arise.

10. At least sixty questions shall be sent by registered letter to the Secretary of the Board of Regents, on or before September 15, 1891.

The following assignments of topics were made:

Physiology and Hygiene, Wm. C. Wey; Surgery, George Ryerson Fowler; Obstetrics, William Warren Potter; Anatomy, William S. Ely; Chemistry and Materia Medica, Maurice J. Lewi; Pathology and Diagnosis, J. P. Creveling; Theory and Practice and Therapeutics, Eugene Beach.

Drs. Fowler, of Brooklyn, and Lewi, of Albany, were selected as members of the Questions and Syllabus Committee. Dr. Potter moved, and it was carried, that in regard to printed matter the form of heading be submitted to the Secretary of the Board of Regents. Dr. Creveling moved, and it was so ordered, that a circular letter be sent to the members and delegates of the State Medical Society by the Secretary, containing such features as would

give them a knowledge of our proceedings and plans. On motion, the Board adjourned subject to the call of its officers.

W. C. WEY, *President.*

MAURICE J. LEWI, *Secretary,*
71 Lancaster St., Albany, N. Y.

THE AMERICAN ASSOCIATON OF OBSTETRICIANS AND GYNECOLOGISTS.

THIS hard-working medical organization has recently held its fourth annual meeting, and the proceedings will be published in the abstracts of the *American Journal of Obstetrics* for October.

The attendance was good, and the scientific work it accomplished was eminently satisfactory. The President, Dr. A. H. Wright, of Toronto, in his address gave a résumé of the purposes of the organization, and especially its negotiations with the Congress of American Physicians and Surgeons with reference to membership in that body. We wish we had space to print it in full, for it will be found full of interest to many.

The New York Academy of Medicine, where the meeting was held, on the 17th, 18th, and 19th days of September, is a splendid building, and the Association was treated most handsomely by the officials that controlled the edifice. A banquet was held on Friday evening, Sept. 18th, at which forty covers were laid, and the following toasts were given: The American Medical Association, responded to by Dr. Henry O. Marcy, of Boston; The American Gynecological Society, response by Dr. E. H. Grandin, of New York; The American Association of Obstetricians and Gynecologists, response by Dr. L. S. McMurtry, of Louisville; The New York Academy of Medicine, response by Dr. Daniel Lewis, of New York; *The American Journal of Obstetrics*, response by Dr. Paul F. Mundé, of New York; The Dominion Medical Societies, response by Dr. Adam H. Wright, of Toronto. This dinner was given in the banquet room of the Academy, which is a most delightful place for such a feast. Taken all together, the fourth annual meeting of this Association has demonstrated the vitality and strength of the organization in a remarkable degree. It now numbers over eighty members, composed of active, progressive, and competent men, who are making themselves felt in the professional world.

Dr. A. Vander Veer was elected President for the ensuing year, and the next meeting will be held in St. Louis, in September, 1892.

THE OPIUM TREATMENT OF PERITONITIS.

It gives us great pleasure to call the attention of the profession to the report of a case of peritonitis by Dr. Himmelsbach, that appears in this number of the Journal. It illustrates well the great superiority of the *true* Alonzo Clark morphine treatment of acute general peritonitis over all other forms of treatment.

In this case the salts treatment had been tried and had failed; the small-dose morphine treatment had been tried with lamentable results, and when the child was brought to the hospital, her condition was exceedingly critical. *Morphine given for its effect, regardless of size of dose*, saved the child's life. Think of it! One hundred and seventy grains of morphine given hypodermically within seventeen days to a child ten years of age, one *single* dose containing *five* grains, and several containing, each, *four* grains, and the respiration not falling below fifteen per minute! Still there are a great many medical men who say, and apparently think, that there is no especially great tolerance for the drug in acute peritonitis, and they are afraid to save their patients' lives. Only ten days ago we actually heard a physician say that he had had a case of acute peritonitis in a young girl to whom he gave at one dose as much as three-quarters of a grain of morphine hypodermically, and he was afraid to go further, *preferring to have the patient die of peritonitis than of morphine.* The paitient died of course, and such a case would be reported as a failure of the morphine treatment instead of a failure of the judgment of the physician, as it should be.

"Give opium to within an inch of your patient's life," was the direction that Dr. Clark gave one of his assistants. A good rule to follow is to give the morphine in doses large enough to keep the patient absolutely free from pain and in a semi-narcotized condition, even if the respirations fall as low as ten or eight per minute in securing that condition. Del. R.

MEDICAL PRACTICE IN CONNECTICUT.

The following neat bit of sarcasm under the above heading appeared in the *Boston Medical and Surgical Journal*, August 27, 1891:

The *Monthly Bulletin of the Connecticut Board of Health* contains the following reply, sent to a doctor inquiring of a State official if he would be allowed to practise in Connecticut by registering his name and the college from which he graduated: "Sir: Anybody

can practice medicine in Connecticut. You do not need to register; you do not need a medical diploma; you do not need to know the difference between opium and peppermint; you do not, indeed, need to know anything. You can simply come and live here, and begin to practise. The laws of Connecticut will sustain you in collecting your fees for professional services, if you render any which you choose to call such. But if you undertake to carry me or my trunk to the depot for pay, you must get a license. If you peddle matches or peanuts, you must get a license. If you collect the swill from your neighbors, to feed your pigs, you must get a license. If you want to empty your cesspool, you must get a license. But you can practice medicine in Connecticut *without a license.*"

Verily, Connecticut has no need of a State Medical Examining and Licensing Board! She is able to manufacture nutmegs, sell peanuts, and commission her doctors without the aid of such nuisances as modern statutory enactments.

THE EXEMPTS.

THE *Post Graduate*, one of the most enterprising quarterly journals, is doing splendid work in the cause of higher medical education. Its editorial columns for July fairly bristle with pointed paragraphs and sayings, from which we regret we have only space to extract the following:

One of the most absurd claims of the gentlemen who succeeded in passing this bill exempting certain students from the Medical Examiners' Law, was that there was a contract made with the medical students of the Long Island College Hospital, by which it was promised that they would be graduated under the old law. This is all nonsense. There can be no contract unless there are two parties. Did any one of these students agree to stay under the then existing law, until he received his diploma? Not one. Medical students never make any such contract. They attend one course at one college, another at another, and so on. But even if they did, every college in this State knew that at any moment the Legislature was likely to change the existing conditions. They began the study of medicine with this knowledge. The college could not have made such a contract, even if the students had asked them to, and that they did was an after-thought. No injustice was done these gentlemen. They ought to have been glad that they were to be the first to inaugurate the new law in this State, but they have chosen the ignominious position of begging to be released from bearing an obligation they ought to have been proud to assume. They will live long enough, we trust, to regret having put anything in the way of elevating the scientific and social position of the profession into which they are to enter.

A MEDICAL MECCA.

The City of St. Louis will be entitled to the banner as a center of attraction for medical men during the week beginning October 12, 1891. The Mississippi Valley Medical Association will hold its seventeenth annual meeting there October 14th, 15th and 16th; the Association of American Medical Editors will also convene during the same week; the Board of Trustees of the American Medical Association will hold an adjourned meeting at that time; and, finally, the Executive Committee of the Inter-Continental Medical Congress will convene for the organization of the Congress during the same eventful week. This latter will be a most important meeting, and the chairman, Dr. Charles A. L. Reed, of Cincinnati, is desirous that all interested shall meet and confer with the committee, with a view to the perfection of this most important medical organization. Surely the attractions are many for physicians at St. Louis during the mid-October season.

Personal.

Dr. William C. Bailey, of Albion, N. Y., has recently been appointed Professor of Theory and Practice of Medicine and Clinical Medicine, and director of the bacteriological laboratory, in the Tennessee Medical College at Knoxville No better selection could have been made to fill this vacancy, and we congratulate the faculty upon securing Dr. Bailey, though Western New York will be sorry to lose this accomplished physician.

Dr. Julius Pohlman, who has been in Europe for the past six months, has returned and opened an office at 367 Franklin street, for the treatment of diseases of the eye and ear, to which specialties he will hereafter give attention. Hours, 9 A. M. to 1 P. M., and 4 to 5 P. M.

Dr. John B. Hamilton, formerly Supervising Surgeon-General United States Marine Hospital Service, has removed to Chicago. His practice is limited to surgery and office consultations. Office, Sherman House. Hours, 11 A. M. to 2 P. M.

Dr. A. A. Hubbell, of 212 Franklin street, Buffalo, announces that from September 1, 1891, his office hours will be from 9 A. M. to 1 P. M.

Society Meetings.

The District Medical Societies of Northern Ohio, comprising the North-Western Ohio Medical Society, the North Central Ohio Medical Society, and the North-Eastern Ohio Medical Society, will hold a joint meeting at Mansfield, on Thursday, Friday, and Saturday, November 5th, 6th, and 7th. On Thursday evening, the members will be entertained by a reception given in honor of the association by the Hon. John Sherman, and on Friday evening by a reception given by the Hon. M. D. Harter. Every arrangement has been made to make this meeting a pleasant and profitable one, and we trust that a full attendance may be had. Ample hotel accommodations will be arranged for; and an effort will be made to secure reduced rates on all the railroads of Ohio. The following committee of arrangements has been appointed: Dr. R. Harvey Reed, Dr. J. W. Craig, and Dr. Geo. Mitchell, all of Mansfield.

JAMES A. DUNCAN, M. D.,
X. C. SCOTT, M. D.,
R. HARVEY REED, M. D.,
Joint Committee.

At the Congress of American Physicians and Surgeons, recently held in Washington, D. C., the following Buffalo physicians were present:

Drs. Bartow, Cary, Crego, Howe, Krauss, Park, Parmenter, Potter, Putnam, Snow and Stockton. Papers were presented and read by Drs. Bartow, Howe, Park, Stockton, and Krauss.

Dr. James W. Putnam, of Buffalo, was elected a member of the American Neurological Association, his thesis being entitled, Complete Athetosis with Autopsy.

Dr. Edward B. Angell, of Rochester, a former associate editor of this journal, was also elected to active membership in the American Neurological Association, and had the honor of reading his thesis on Thomsen's Disease, before the association.

New York State Society of Railway Surgeons. — The first meeting of this Society will be held in the parlors of the Hotel Bensonhurst, at Bensonhurst-by-the-Sea, Long Island, October 27,

1891. A full attendance is desired; programmes of the meeting may be obtained by addressing Dr. Geo. Chaffee, 201 47th street, Brooklyn.

Journalistic Notes.

Dr. Bransford Lewis at Home. — In another column will be found the announcement of *The Fortnightly M. D.*, to be published at St. Louis by our talented foreign correspondent, who has just returned from an extended European tour, and is now in New York City, placing his advertising. Considerable interest and no end of curiosity has been aroused among medical men concerning the "guessing" of the title to the Doctor's journal, the weird emblem of which appears in connection with his advertisement. The result of the "guess" brings out some facts of peculiar interest to those who use the advertising pages of medical journals. Out of a combined circulation of about 150,000 in this and other journals, nearly 39,000 answers were received in three months, which goes to prove that even the smallest advertisements are read by western physicians.

The number guessing correctly, 6,422, was comparatively small, but Dr. Lewis can congratulate himself upon having on his list not only the *brightest thinkers* in the country, but doctors who will, no doubt, appreciate his efforts in the journalistic line. To those of our readers who missed on their guess, we would say, take another look at the design and see how simple it is (after you know). The letters "F. M. D." were no doubt easily read by those familiar with the deaf and dumb alphabet, while the moon's quarter (fortnightly) makes the interpretation complete. The instruments crossing under the monogram in the form of "X" are construed to mean "by," thus "Fortnightly M. D., by Bransford Lewis, St. Louis." We anxiously await the initial number, which is to appear January 1, 1892.— *Medical Herald, St. Joseph, Mo.*

A recent death from chloroform, reported in the *Indiana Medical Journal*, was attended by such disagreeable consequences to the physician, as to give point to the moral, that except in case of obstetrics or emergency, anesthetics should not be given by a physician without the presence of another physician.—*American Lancet.*

Book Reviews.

PRINCIPLES OF SURGERY. By N. SENN, M. D., Ph. D., Professor Principles of Surgery and Surgical Pathology in the Rush Medical College, Chicago, Ill.; Professor of Surgery in the Chicago Polyclinic; Attending Surgeon to the Milwaukee Hospital, etc., etc., etc. Illustrated with 109 wood engravings. Octavo, pp. xiii.—611. Philadelphia and London: F. A. Davis. 1890. Price, cloth, $4.50; sheep, $5.50 net.

This work, as its title indicates, is a treatise on the *principles* of surgery, pure and simple, and it must be so regarded and accepted in any criticisms that may be offered *pro* or *con* by its reviewers.

The author says in his preface: "It has been my aim to write a book for the student and general practitioner, which should, at least in part, fill this gap in surgical literature, and which should serve the purpose of a systematic treatise on the causation, pathology, diagnosis, prognosis, and treatment of the injuries and affections which the surgeon is most frequently called upon to treat."

It is a work based largely on the personal experience and study of the author, who fortunately has a rich mine of the former to draw upon, and a logical, studious brain to formulate and exemplify deductions therefrom for presentation to his readers.

The twenty-four chapters of the book bristle with original research, and teem with valuable thoughts, that are presented in an instructive and readable form. Senn is a clear writer, whose sentences are never involved, and hence he is not likely to be misunderstood. As might be expected in a modern work, written by a modern man, considerable prominence is given throughout the treatise to the subject of bacteriology. Chapter V., on Pathogenic Bacteria, is one of the best expositions we have seen of this intricate and many-sided question. A careful reading of this chapter will repay even the most astute bacteriologist, while it is so simple in its verbiage, and so methodical in its arrangement, as to attract the tyros in this field of study. The four chapters on Necrosis and Suppuration are equally simple, direct, instructive and masterly. And so we might go on through the volume, where we find so much to praise and so little to condemn, but we should weary the reader with tedious homilies, or consume his time with verbose iterations. This is a book that must be read to be appreciated, and we shall feel content if we have said anything that will stimulate even a few to possess it and study it for themselves.

It is printed in clear letter, on dull finished paper, which makes it pleasant reading for the eyes, while its matter entertains the mind. Its illustrations are chiefly in Pathology and Bacteriology, and help to give a completer understanding of the subjects which they elucidate.

The work has already become a standard text-book in the colleges, and will long continue to be quoted by teachers as the first and foremost authority on the principles of surgery.

Wood's Medical and Surgical Monographs, consisting of original treatises and reproductions in English of books and monographs selected from the latest literature of foreign countries, with illustrations, etc. Published monthly. Vol. XI., No. 1, July; No. 2, August; No. 3, September, 1891. New York: Wm. Wood & Co. $10.00. $1.00 per part.

The July number of the current volume contains the following titles by well-known authors: Hay Fever and Paroxysmal Sneezing, by Sir Morell Mackenzie, M. D.; Tuberculosis of the Bones and Joints, by Dr. Fedor Krause; and, A Study of the Malignant Diseases of the Upper Air Tract, by Francke H. Bosworth, M. D.

The August number contains the following monographs: Modern Abdominal Surgery, by Sir T. Spencer Wells, Bart.; Subjective Noises in the Head and Ears: Their Etiology, Diagnosis and Treatment, by H. MacNaughton Jones, M. D.; Notes on Surgery for Nurses, by Joseph Bell, M. D.; and Surgical Treatment of Typhlitis, by Frederick Treves, F. R. C. S.

The September part brings out the following: Foods and Dietaries: A Manual of Clinical Dietetics, by R. W. Burnett, M. D.; Stertor, Apoplexy, and the Management of the Apoplectic State, by Robert I. Bowles, M. D.; and the Index of Volume XI.

Many of these subjects are copiously illustrated, and all are ably and interestingly handled. This volume bears further testimony to the wisdom and liberality of the publishers.

Annual of the Universal Medical Sciences. A Yearly Report of the Progress of the General Sanitary Sciences throughout the World. Edited by Charles E. Sajous, M. D., and Seventy Associate Editors, assisted by over Two Hundred Corresponding Editors, Collaborators and Correspondents. Illustrated with chromo-lithographs, engravings and maps. Five volumes. Philadelphia: F. A. Davis. 1891.

The fourth series of this invaluable work appears in its usual handsome form, and with all its wonted vigor and excellence.

Though published slightly later than usual, it is none the less welcome, nor diminished in usefulness. The only wonder is that the accomplished editor, indefatigable worker though he is, can bring out this stupendous work with such regularity and perfection as have characterized the four issues that are now in the hands of the profession. The slight delay in the present series has been due to causes that must ever menace all human enterprises—sickness and death. Two of the editor's three confidential secretaries were thus removed from active participation in the preparation of these volumes—one by grievous illness, prolonged in character, and the other fell a victim to fatal pneumonia. To the remaining faithful aid, Miss N. I. McCarthy—we gladly mention her name—the editor pays a graceful tribute in his preface.

The present series bears abundant evidence of the wisdom of the projector and editor of the *Annual*, in its every volume, department, section and page, and it has become a necessity for teachers, practitioners, authors, and students of medical literature. None of these can afford to do without it, and many other scientific workers ought to possess it. It has become a part of the essential periodical literature of American medicine, and will, no doubt, continue to appear during the future years on much the same lines that at present mark its unexampled prosperity. We have nothing but praise for both editor and publisher in giving to the profession such a beautiful and useful work. It should be encouraged by a liberal patronage in all lands.

MANUAL OF CLINICAL DIAGNOSIS. By Dr. OTTO SEIFERT, Privatdocent in Würzburg, and Dr. FRIEDRICH MULLER, Assistant der II. Med. Klinik in Berlin. Translated from the fifth German edition, enlarged and revised, with the permission of the author, by WILLIAM BUCKINGHAM CANFIELD, A. M., M. D. (Berlin), Fellow of American Academy of Medicine, etc., etc., etc. Second English edition, revised and enlarged, with fifty illustrations and one colored plate. G. P. Putnam's Sons, New York, 27 W. 23d St.; London, 27 King William St., Strand. The Knickerbocker Press. 1890.

The fact that this little book has reached a fifth edition in the German, and a second in English, proves that it is at least popular. Nevertheless, popularity is no criterion of the true value of a book which is intended as an educational work. This book belongs to a class which should be utterly condemned by all men who are striving to give thorough instruction to their students. In the preface to the first edition the authors say: "In selecting and

arranging this material, we have been led by the experience gained in *holding courses*, and we have also endeavored to consider the *practical needs of the student* and physician by noting only what is reliable, and omitting everything self-evident and of secondary importance." In other words, this book is intended as one to which a student may refer just before going up for examination, and cram his head full of a certain number of important facts relative to diseases, so that he can pass his examination well, even though he knows nothing of the true *clinical* picture of any given disease.

In this work on "*clinical* diagnosis," the "omission of everything self-evident and of secondary importance," is so complete, that in discussing the various diseases which are characterized by changes in the blood, namely anemia, chlorosis, leucocytosis, leukemia, pseudo-leukemia, and pernicious anemia, no mention whatever of any truly *clinical* symptoms is made, but merely the changes in the character and numbers of the blood corpuscles are noted.

The subject of typhoid fever is dismissed in a little over half a page. No mention is made of diarrhea, nose-bleed, right iliac tenderness and gurgling, nor is the possibility of hemorrhage from the bowels or of intestinal perforation even referred to. Yet this is called a manual of *clinical* diagnosis. It is unnecessary to make further references, as the book is made on the same plan throughout, a plan which gives a very superficial knowledge, and is worthy only of utter condemnation by all who have at heart the thorough education of medical students. DeL. R.

BOOKS AND PAMPHLETS RECEIVED.

Regional Anatomy in its Relation to Medicine and Surgery. By George McClellan, M. D., Lecturer on Descriptive and Regional Anatomy at the Pennsylvania School of Anatomy; Professor of Anatomy at the Pennsylvania Academy of the Fine Arts; member of the Association of American Anatomists, Academy of Natural Sciences, Academy of Surgery, College of Physicians, etc., of Philadelphia. Illustrated from photographs taken by the author, of his own dissections, expressly designed and prepared for this work, and colored by him after nature. "L'anatomie n'est pas telle qu'on l'enseigne dans les ecoles."—Bichat. In two volumes. Vol. I. Philadelphia: J. B. Lippincott Company. 1891.

Tables for Doctor and Druggist. Comprising: I. Table of Solubilities. II. Table of Reactions and Incompatibles. III. Table of Doses and Use of Medicines. IV. Table of Specific Gravities. V. Table of Poisons and Antidotes. Compiled by Eli H. Long, M. D, Professor of Materia Medica Buffalo College of Pharmacy; Adjunct Professor of Materia Medica Medical Department, University of Buffalo. Detroit: Geo. S. Davis, Medical Publisher. 1891.

Pulmonary Consumption, a Nervous Disease: Considered as such from a Practical, a Clinical, and Therapeutic Standpoint. By Thomas J. Mays, M. D., Professor of Diseases of the Chest in the Philadelphia Polyclinic and College for Graduates in Medicine; Visiting Physician to the Rush Hospital for Consumption of Philadelphia; Fellow of the College of Physicians of Philadelphia: member of the Philadelphia County Medical Society; member of the Neurological Society of Philadelphia, etc., etc. Physicians' Leisure Library. Geo. S. Davis, Detroit, Mich. 1891. Price, cloth, 50c.; paper, 25c.

Essentials of Physiology arranged in the form of Questions and Answers, prepared especially for students of medicine. By H. A. Hare, B. Sc., M. D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia; Physician to St. Agnes's Hospital, and to the Medical Dispensary of the Children's Hospital; Laureate of the Royal Academy of Medicine in Belgium, of the Medical Society of London, etc.; Secretary of the convention for the revision of the Pharmacopeia. 1890. Saunders' Question-Compends, No. 1. Third edition, thoroughly revised and enlarged, by the addition of a series of handsome plate illustrations taken from the celebrated Icones Nervorum Capitis of Arnold. Philadelphia: W. B. Saunders, 913 Walnut street. 1891.

Addresses, Papers, and Discussions in the Section of Obstetrics and Diseases of Women at the Forty-second Annual Meeting of the American Medical Association, at Washington, D. C., May 5-8, 1891. Chicago: Printed at the office of the Association. 1891.

A Short Manual of Analytical Chemistry, Qualitative and Quantitative, Inorganic and Organic. Arranged on the principle of the course of instruction given at the South London School of Pharmacy. By John Muter, M. A., Ph. D., F. R. S. E., F. I. C., F. C. S., Analyst to the Metropolitan Asylum Board; Public Analyst for Lambeth, Wansworth, Southwark, Newington, Rothershithe, and the Linsey Division of Lincolnshire; Past President of the Society of Public Analysis; author of Pharmaceutical and Medical Chemistry (Theoretical and Descriptive), A Key to Organic Materia Medica, late editor of *The Analyst*, etc., etc. First American from the fourth English edition, edited by Claude C. Hamilton, M. D., Ph. G., Professor of Analytical Chemistry in the University Medical College and the Kansas City College of Pharmacy; Professor of Chemistry in the Western Dental College of Kansas City, Missouri. Philadelphia: P. Blakiston, Son & Co. 1012 Walnut street. 1891.

Essentials of Anatomy and Manual of Practical Dissection, together with the Anatomy of the Viscera. Prepared especially for Students of Medicine By Charles B. Nancrede, M. D., Professor of Surgery and of Clinical Surgery in the University of Michigan, Ann Arbor; Corresponding member of the Royal Academy of Medicine, Rome, Italy; late Senior Surgeon to Episcopal Hospital; late Surgeon to Jefferson Medical College Hospital; formerly Lecturer on Osteology, etc., in Medical Department, University of Pennsylvania; late Professor of General Orthopedic Surgery in Philadelphia Polyclinic, etc. Fourth edition, revised and enlarged by an Appendix containing Hints on Dissection, by J. Chalmers Da Costa, M. D., based upon the last edition of Gray's Anatomy. Thirty handsome full-page lithographic plates in colors, and 188 fine wood cuts. Philadelphia: W. B. Saunders, 913 Walnut street. 1891.

Therapeutics: Its Principles and Practice. By H. C. Wood, M. D., LL. D., Professor of Materia Medica and Therapeutics, and Clinical Professor of Diseases of the Nervous System, in the University of Pennsylvania. A Work of Medical Agencies, Drugs and Poisons, with Especial Reference to the Relations between Physiology and Clinical Medicine. The eighth edition of Treatise on Therapeutics, re-arranged, re-written, and enlarged. Philadelphia: J. B. Lippincott Company. 1891.

Syllabus of the Obstetrical Lectures in the Medical Department of the University of Pennsylvania. By Richard C. Norris, A. M., M. D., Demonstrator of Obstetrics, University of Pennsylvania; Physician to the Methodist Episcopal Hospital; Obstetrical Registrar, Philadelphia Hospital. Second edition. Philadelphia: W. B. Saunders. 1881.

Second Report of the Johns Hopkins Hospital. For the Year ending January 31, 1891. Baltimore: The Johns Hopkins Press. 1891.

Sulphuring or Bleaching Dried Fruit a Mistake, If Not a Crime. By Joel W. Smith, M. D., Charles City, Iowa.

Conditions Following Parturition Requiring Abdominal Section. By E E. Montgomery, M. D., Philadelphia. Reprint: Transactions Med. Soc. State of Penn. 1891.

Three Cases of Epithelial Grafting from the Horny Epidermis, with remarks by C. R. Kibler, M. D., of Corry, Pa. Reprinted from the *Journal of the American Medical Association*, August 8, 1891.

Evidence of Arsenical Poisoning in the Snook-Herr Wedding Guests. By J. W. Irwin, M. D. Reprint: *New York Medical Journal*, August 1, 1891.

Addresses, Papers, and Discussions in the Section of Surgery and Anatomy, at the Forty-second annual meeting of the American Medical Association, at Washington, D. C., May 5–8, 1891. Chicago: Printed at the office of the Association. 1891.

Therapeutics of Diphtheria. By Dr. Joseph Burghardt, Practising Physician in Vienna. From a lecture delivered at the meeting of the Council of Vienna Physicians, April 8, 1889. Translated by Charles Raettig. Translation authorized by the Lecturer. New York: J. H. Vail & Co. 1891.

One Thousand Cases of Labor, and Their Lessons. By G. W. H. Ex-Kemper, M. D., Member of the Delaware County (Ind.) Medical Society; President of the Indiana State Medical Society, Muncie, Ind. Reprint: *The Medical News*, Sept. 12, 1891.

On Unusual Methods of Acquiring Syphilis, with Reports of Cases. By L. Duncan Bulkley, A. M., M. D., of New York. Reprint: *The Medical News*, March 2–9, 1889.

Proceedings and Addresses at a Sanitary Convention held at Niles, Mich., Feb. 5 and 6, 1891, under the direction of the State Board of Health and a committee of citizens of Niles. Lansing: Robert Smith & Co., State Printers and Binders. 1891.

A Few Thoughts on the Technique of Hysterectomy. By Joseph Eastman, M. D., President and Professor of Diseases of Women and Abdominal Surgery, Central College of Physicians and Surgeons, Indianapolis. Reprint: *The Medical News*, August 1, 1891.

A Clinical Study on Alopecia Areata and its Treatment. By L. Duncan Bulkley, A. M., M. D., New York. Reprint: *The Medical News*, March 2, 1889.

On the Value of Frequently-Repeated Doses of Arsenic in the Treatment of Bullous Diseases of the Skin, especially in Children. By L. Duncan Bulkley, A. M., M. D. New York. Reprint: *The New York Medical Journal* for April 13, 1889.

Cornell University Agricultural Experiment Station. Bulletin 29. Agricultural and Chemical Divisions. July, 1891. Cream Raising by Dilution. II. The Effect of a Delay in Setting on the Efficiency of Creaming. III. Application of Dr. Babcock's Centrifugal Method, to the Analysis of Milk, Skim-Milk, Buttermilk, and Butter. IV. The Relation of Fibrin to the Effectual Creaming of Milk. Published by the University, Ithaca, N. Y. 1891.

NOTICE TO CONTRIBUTORS. — We are glad to receive contributions from every one who kows anything of interest to the profession. Articles designed for publication in the JOURNAL should be handed in before the first day of the month. The Editors are not responsible for the views or opinions of contributors. All communications should be addressed to the Managing Editor. 284 FRANKLIN STREET, BUFFALO, N. Y.

Buffalo Medical and Surgical Journal

Vol. XXXI. NOVEMBER, 1891. No. 4.

Original Communications.

THE GENERAL AND SPECIAL MEDICAL SOCIETIES OF AMERICA.[1]

By ADAM H. WRIGHT, M. D., Toronto.

When we separated after our pleasant and profitable meeting in Philadelphia last September, it was expected that we would meet this year in Washington as members of the Congress of American Physicians and Surgeons. The Congress, however, has refused to admit us, and, therefore, we are not going to Washington.

I desire, with the permission of our executive council, to place on record a plain statement of facts respecting the negotiations which have been carried on between that body and our Association. In the year 1886, after careful consideration on the part of certain representative physicians and surgeons of the United States, it was decided to form such a Congress. Preliminary invitations were sent to the various special societies, asking for their assistance and coöperation in the new undertaking. All the societies then in existence, except one, returned favorable replies. The American Gynecological Society alone refused to coöperate. In the report of the meeting of this society for 1887, which appeared in the *New York Medical Record*, we find the following words: "The proposition to become a part of the American Congress of Physicians and Surgeons was not adopted." The promoters of the proposed confederation were naturally disappointed and considerably discouraged by the action of this strong and able society. They desired a representation of the important subjects of obstetrics and gynecology. After a conference, some strong friends of the Congress decided to organize a new society of obstetricians

1. The President's annual address to the American Association of Obstetricians and Gynecologists, delivered at the fourth annual meeting held at the New York Academy of Medicine, September, 1891.

and gynecologists. A preliminary meeting of a number of prominent obstetricians and gynecologists was held in Buffalo, April 19, 1888, with that object in view, and the result was that the American Association of Obstetricians and Gynecologists was organized, not in opposition to any other society in any sense, but largely in the interest of the new Congress. For some months these promoters of our Association did some prodigious work in their efforts to perfect the organization. I have been advised to mention no names in this connection, and I rather regret that I have acted on such advice, because I feel that I am scarcely doing justice to men who worked quietly but persistently for many weary months to make the Association a credit alike to the continent of America and the Congress which it expected to enter.

In due time our organization was fairly completed. Those who had worked so faithfully and so unselfishly began to feel that their efforts had been crowned with success. A formal application for admission was sent to the Congress. In the meantime, however, a change had come over the society, which had formerly opposed the proposed Congress. Whether this marvelous change was brought about by our organization, I know not; but it was a singular coincidence that the applications from the old Gynecological Society and the new Association of Obstetricians and Gynecologists for admission to the Congress, were practically made at one and the same time. After some deliberation by the executive authorities of the Congress, it was decided that the society which had shown pronounced hostility to the Congress up to the date of its sudden conversion and application for admission should be received, and that the new organization, which had been formed to assist the confederation in a serious emergency, should be put on trial for a couple of years. In accordance with this remarkable decision, the following resolution was passed:

"*Resolved*, That it is the sense of this Executive Committee that they will not consider the application of any society which has not held at least two annual meetings."

This decision was received with a certain amount of surprise, but with becoming meekness and humility; and we entered into our period of probation with some feelings of disappointment, but with strong hopes that our work would be judged on its merits, and duly recognized at the proper time. At the end of our second year we felt extremely gratified at the work which had been accomplished by our members. We felt certain that our two pub-

lished volumes of Transactions would quite fulfil the requirements which had been exacted from us. These volumes were duly filed, substantially constituting our second application, to which we received no reply for many months.

Shortly after our meeting in Philadelphia we received a communication asking for twelve copies of each volume of our Transactions. This was a third surprise and disappointment to us, but we presumed that the request was made in good faith, and we acted accordingly. Our third meeting was so successful from every point of view, that we thought a perusal of the Transactions would strengthen any favorable impressions which had been created by the former two. It was, to a certain extent, embarrassing to us, because we were unable to announce definitely the time and place of our next meeting. Our third volume was completed as soon as possible, and the thirty-six books forwarded to the Executive Committee of the Congress. When all the evidence as to our position was received, the committee did not arrive at a conclusion suddenly or rashly; they took ample time for deliberation, and while they were deliberating we were waiting. Month after month dragged along, and still the decision came not. The patience of our Council during these months reached a sublimity which appeared to me almost ridiculous. At last, a meeting of the Executive Committee of the Congress of American Physicians and Surgeons was held in Philadelphia, April 26, 1891, and shortly we received an unofficial intimation that we would not be admitted to the Congress.

I have endeavored to give you a plain statement of what appears to me one of the most extraordinary transactions known to medical history. The question naturally arises, Why were we accorded such treatment? I am unable to answer. A rumor has reached me to the effect that the chief argument used against us was that our Association really represented nothing more than a duplication of the work of other sections, and for that reason should not be admitted. I have nothing to do with such an argument, and care not whether it be considered good, bad, or indifferent. I will remove the necessity of using it by saying that we concede that the Congress had a perfect right to refuse to admit us if its members thought fit. We insist, however, that it had no right to subject us to humiliation such as this; it had no right to place us on probation for an extended period, and then absolutely ignore the essence of the implied contract. The resolution of the Congress required

certain things from us. We have fulfilled those requirements in every particular. We actually came into existence in the interest of the Congress; we have supported it loyally in every particular; we have shown no particle of antagonism to any of its sections; we have, as a matter of fact, patiently submitted to much inconvenience through the delay in sending its singular ultimatum. Is it possible that the majority of the members of that great organization will feel proud of the actions of their executive? I have considered the matter in all its aspects, and I cannot conceive how the members of the Congress can reasonably defend the methods of their committee.

Well, gentlemen, what are we now to do? It gives me unbounded pleasure to assure you that our Executive Council holds no divided opinions. The necessities of the case compel us to bid the Congress a sad farewell, but in doing so we indulge in the hope that we may be permitted to continue our existence, which we have found exceedingly pleasant as well as extremely profitable. Our Association is alive to-day; it is going to live; it is going to thrive; it is going to do a great work on this vast continent. I say this in no boasting spirit. I desire to assume no air of bravado. I feel fully impressed with the responsibility I assume when I say that we have a grand future before us. I, who have done so little for you, can express myself with greater freedom than could others who have borne so nobly the burden of organizing this magnificent society. I have witnessed the efforts of our founders with profound admiration; I have watched their zeal, their devotion, their untiring energy, with a feeling of wonder; I have viewed their boundless enthusiasm, their wondrous capacities for work, and their unselfish devotion to each other and our common cause, with perfect delight. In addition, it gives me great pleasure to refer to the dignified bearing of our councilors under somewhat trying circumstances. In our negotiations with the Congress, I know of no act on our part that will ever bring the blush of shame to any of our members. While referring to the actions of our office-bearers, I cannot refrain from also referring to the loyal support they have ever received from the ordinary Fellows of our Association. It appears to me that our prospects were never brighter than they are today. The main object of our Association, "the cultivation and promotion of knowledge in whatever relates to abdominal surgery, obstetrics and gynecology," is ever kept in view by one and all; and the results in three short years, the evidence of which may be found in three vol-

umes of our Transactions, are such as will inspire us with confidence and fill us with hope in the future.

Let it be our duty, as well as our pleasure, to worthily continue the work which has been so auspiciously begun. Let envy, hatred, and all uncharitableness toward other societies be ever kept far from us. Let us forget the indignities that have been heaped upon us. Let our memories of the past pertaining to our own work ever remain as pleasant as they are today.

It gives me pleasure and satisfaction to call attention to the fact that, geographically speaking, this Association is American in the broadest sense of the word. As our President of last year expressed it, "the Association is not limited to the United States, but only by the boundaries of the Western Continent." I know of no other medical society in existence that is essentially continental in character, and I am glad to be able to assure you that this feature of the organization is highly appreciated by my countrymen in the goodly-sized Dominion north of this flourishing Republic. It happens by an unfortunate coincidence that the meeting of the Canadian Medical Association is being held in Montreal concurrently with this. As we desired to treat that Society with no discourtesy, we have had but little to say about this meeting in Canada. I am much gratified, however, that Dr. Ross and myself have been able to propose the names of some Canadians, and I am pleased that you have been good enough to accept them to membership without putting them on probation for two or three years.

I would like to make a few remarks on the subject of medical societies, with a view to our position at the present juncture; and I do so with considerable diffidence, because my opinions may be distasteful to some of our Fellows, and to some warm friends outside. My remarks, however, will simply represent my own individual views, and you may take them for what they are worth.

We are now perfectly free and untrammeled in every respect, and it may be well to consider what position we should assume in regard to other societies. Probably all will admit the possibilities of great dangers arising out of specialties. This subject has caused considerable discussion in all parts of the world during recent years. It is not my purpose to discuss the general aspects of the subject now; but in reference to societies, I would regret very much to see a too-well-marked line of demarcation between the specialists and the great mass of general practitioners of this country. What should be the greatest medical organizations in the United States

and Canada respectively? In my opinion, the American Medical Association and the Canadian Medical Association. I have long had a very decided opinion that the greatest medical organization that has ever existed is the British Medical Association. The great mass of British practitioners of all sorts and conditions belong to it, and take pride in their membership. It contains no less than thirteen thousand eight hundred members. At the recent meeting at Bournemouth, a large portion of the brightest lights of Great Britain were present, and devoted their best energies toward making the meeting a success. This is the rule from year to year, and the great society is growing with wondrous rapidity. In this country it seems to me that too many of the leaders of the profession are conspicuous by their absence from the meetings of the American Medical Association. Many of the men referred to are the peers of the best men that can be found in any nation or any clime. Is it not unfortunate that so many of them miss what should be the best opportunity of meeting the rank and file of the profession in their own country? Is there no remedy for this unfortunate condition of things? It would seem to me that all should unite to make the national society the greatest in the land, and that all local and special societies should cordially work together for that purpose. I am pleased to note that many of our Fellows are enthusiastic workers in the American Medical Association, and I hope that they and all others will give it at least as loyal a support in the future as they have in the past.

I was particularly struck recently with an example of the great good which can be accomplished by a meeting of specialists with general practitioners. I had the privilege of attending a very excellent meeting of the Medical Society of the State of New York in February last; and among the many good things there was an admirable discussion on the important subject of appendicitis, valuable alike to those who talked and those who listened. Operations, when required for this condition, may be relegated to those who pay special attention to abdominal surgery, but the best methods of diagnosis should be known to all. The various phases of the question were so thoroughly and ably discussed, that the large assemblage was duly impressed with the importance and correctness of the views expressed. It is impossible to put any proper estimate on the good that may be accomplished by such meetings and discussions. The benefits are not confined to one side, but extend alike to specialists and general practitioners. In speaking of special-

ists, I may say I refer to those who pay special attention to such subjects as obstetrics and gynecology, whether their work be entirely confined to these departments or not. For such, the benefits to be derived by personal contact with intelligent, industrious, and observing general practitioners are incalculable. Such association will do much to keep the specialists from becoming narrow, priggish, dogmatic, and—may I say it?—dangerous.

We meet today in this great city as a society of physicians and surgeons, who may be called specialists in the sense I have indicated. Of course, modern gynecology is understood to include abdominal surgery, which has made such wondrous advances in recent years. I think our work on this continent in these different departments will compare favorably with that done in older countries. A few short years ago the results of our efforts in abdominal surgery were somewhat discouraging. Our mortality rates compared very unfavorably with those of Great Britain and the Continent. Some of the reasons given for this condition of things were positively ludicrous. The history of the evolution of this branch of surgery is so recent as to have been almost the talk of yesterday, and I need not dilate upon it today. What seem more simple now than our methods of cleanliness in surgery—and yet how hard they were to learn! I think, however, I am justified in saying that we have conquered our former serious difficulties, and our high mortalities of from 15 to 50 per cent. in our various kinds of abdominal sections have vanished, I hope, forever.

Our advances in obstetrics, although not so brilliant as those to which I have just alluded, have been quite as valuable, and are exactly in the same line. And yet we have found it difficult to learn, and to teach, that obstetricians should be as scrupulously careful in their methods as abdominal surgeons. I may say, in addition, that this lesson has not yet been learned by a large proportion of our physicians, and we must go on preaching and teaching cleanliness to all our practitioners until it is recognized practically as a criminal offense to neglect to clean the hands, the instruments, and the surroundings of our patients in labor. We are proud of the fact that we have almost driven septicemia from properly conducted maternity hospitals. Let us drive it away from this continent altogether.

In making any allusions to the past year, I am very thankful that I have no obituary references to make respecting our Fellows. Some, however, have been sorely afflicted by family bereavement.

and when our brothers suffer we feel in a sense a certain amount of the weight falling on our own shoulders. Of such matters I shall make no special mention, excepting in one instance. I desire to give expression to the profound sorrow we all feel in consequence of the almost appalling calamity which has befallen our Secretary in the loss of his only—his well-beloved—son, who was alike an ornament to our profession, a worthy citizen of this Republic, a loving son, husband and father, and a most charming and estimable man. What William Warren Potter has done for this Association cannot be told, but has, I am glad to say, been very highly appreciated by all. We know that since the inception of our organization he has given us the benefit of some of the best efforts of his life. We all respect and admire him for what he has done for us; we love him for his rare personal qualities and goodness of heart; we extend to him in his hour of tribulation our warmest sympathies, and our best wishes for him and his for all time to come.

I cannot refrain from making reference to the great loss this country has sustained in the death of Dr. Fordyce Barker. He was not simply a distinguished obstetrician of this continent—he was known abroad almost as well as he was at home—he was one whom the whole medical world admired, respected, and delighted to honor. It was my pleasure and privilege to listen to some of his lectures in my student days, and since that period to read everything from his pen that I could find; and I feel that I am indebted to him for some of the most valuable lessons I have ever learned in the science and art of obstetrics. I desire, therefore, to offer my humble tribute, in addition to the almost countless others from all parts of the globe, to the memory of one of the grandest and noblest physicians the world has ever seen.

In conclusion, I must confess that your choice of a President last year at Philadelphia was more creditable to your good nature than your better judgment. I feel constrained, however, to forgive you for that mistake, and to thank you for myself and for my country. I cannot express the satisfaction it would afford me if any words of mine would encourage you to work with still more vigor and enthusiasm in the future than you have in the past. I feel, however, that that is unnecessary. I think that our Association is not composed of the material that is likely to weaken in the hour of trial. I trust that the troubles that have beset us will be the means of forming the strongest link in the firm chain that binds us together as brothers and co-workers in a good, a great cause.

SHALL WE USE THE UTERINE SOUND TO CORRECT BACKWARD DISPLACEMENTS OF THE UTERUS?[1]

BY CLINTON CUSHING, M. D. San Francisco, Cal.

Professor of Gynecology, Cooper Medical College.

IT IS almost certain that this question will meet very opposite opinions from the members of this Association. Now, as opposition is the very life of, and the cause of progress in such an organization, it is to be hoped that a fair amount of consideration will be accorded this subject. The profession seems divided into three parties. A few who, under no circumstances, would introduce a sound into the uterus to correct a displacement; a large number who would do so under certain circumstances, and a small number who would recklessly do so in almost any case. The object of this communication is to discuss the conditions when we should or should not use the sound.

As all the older members know, gynecology was very poorly, if at all, taught in our medical schools here, or in any part of the world, twenty-five years ago. As a separate branch of practice or study it had scarcely an existence. Therefore, when I received my degree, I knew practically nothing about the diseases peculiar to women, and now began a blind groping after knowledge, at the expense of much anxiety and worry, and at the cost of much unnecessary pain and suffering to the unfortunate women who fell into my hands. Pelvic peritonitis, pelvic abscess, and death followed promptly in a considerable number of cases. The various methods pursued, to relieve the patients of the symptoms of which they complained, were crude. The merits of cleanliness were unknown. My armamentarium consisted of a Fergusson speculum, and a piece of nitrate of silver fastened in a goose-quill. The principal disease to be treated was the so-called ulceration of the cervix. The knowledge of pelvic inflammation and abscess, of tubal disease and extra-uterine pregnancy, possessed by the average practitioner of medicine, was insufficient to be of service in the management of his cases. Little wonder, then, that mistakes and blunders were frequent and disastrous. The intelligent graduate of today can scarcely appreciate the difficulties under which we labored thirty years ago. Happy the gynecologist who has had the road smoothed and made ready for him by the labors and painful experiences of others!

1. Read at the Fourth Annual Meeting of the American Association of Obstetricians and Gynecologists in New York, September, 1891.

A problem presented itself at the outset of my practice which grew in importance continually: Why did a simple treatment of an erosion of the cervix or a cervical endometritis, set up a dangerous pelvic inflammation in one case, when in twenty other apparently similar cases the treatment was not harmful? It has been the good fortune of all of us to have the truth of this question settled during the past few years, largely through the labors and energy of Mr. Lawson Tait. He demonstrated, by many abdominal sections, that pyosalpinx was the common concomitant of acute or chronic pelvic inflammation; this truth has been verified since by many able men in all parts of the world, and the conclusion has been generally arrived, at that the escape of pus or muco-purulent matter from the Fallopian tube into the abdominal cavity is the common cause of pelvic peritonitis.

This point being conceded, I will now proceed to set forth the results of my observations in the use of the uterine sound in replacing retroverted and retroflexed uteri. I will cite a case that, I doubt not, will be recognized as an old acquaintance by all present.

A woman applies for advice concerning the usual symptoms of pelvic disease,—backache, pain in region of uterus and ovaries, inability to stand and walk without increased suffering, with the various reflex symptoms of stomach and head in varying degrees. She gives a history of some acute pelvic inflammation, or not, as the case may be. Upon examination, a marked retroversion of the uterus is found. Perhaps a prolapse of one or both ovaries. The uterus is quite firmly fixed. The tissues about the uterus are not very tender, and the previous history is somewhat obscure.

First, an effort is made by manual and bi-manual pressure to correct the displacement. This failing, the woman is placed upon her elbows and knees, a Sims speculum is introduced and held by an assistant, and now, the cervix being well drawn down by a tenaculum, an effort is made with a firm ball of cotton held in a dressing-forceps to push the body of the uterus forward, the force being applied from the region of Douglas's pouch. If the effort is not successful in loosening the uterus, a firm tampon is applied behind the cervix, and the vagina is filled with cotton, so as to crowd the uterus well up in the pelvis. This procedure is repeated two or three times a week, but without any good result. The troublesome symptoms are not relieved. I now take a stiff copper sound, or, what is better, a number eight Otis's steel urethral sound, and, intro-

ducing it while the woman is in the knee-elbow position, with the cavity backward, describe an arc with the handle of the sound, thus bringing the uterus into a condition of anteversion, with the least possible violence to the uterine mucous membrane.

By this procedure is at once made manifest the firmness of the adhesions between the posterior surface of the uterus and the adjacent structures. If the uterus can be placed in a state of anteversion by the use of a moderate amount of force thus applied, well and good. The effort is abandoned, for the time, if the pain be marked, or unusual force required. A vaginal tampon of glycerine and cotton is applied, and the patient ordered confined to bed for forty-eight hours. This procedure is repeated at the expiration of three or four days, unless inflammation supervenes. If it be found that the uterus cannot be placed in a state of anteversion without the using of great force, or if it be found that the adhesions to the rectum are so firm that when the sound is removed the uterus immediately springs back as though drawn by a rubber band, it is probable that the plan of correcting the displacement by the sound will prove a failure.

During the past ten years I have successfully treated a large number of cases similar to the one described above, have invariably used this method, and I have met but few cases where this plan has proved a failure. Now, an important question arises: How large a proportion of these women were made worse as a consequence of this manipulation? In other words, in how many did some pelvic inflammation supervene? Certainly in not more than one per cent. We are told by some writers that the introduction of any instrument into the cavity of the uterus is a very dangerous procedure. If this is true, why do I have an immunity? For the very simple reason that I have learned to draw the line regarding any kind of intrauterine instrumentation, where, from the history of the case, or from a very thorough and careful manual and bimanual examination, there exists a reason for believing that there is disease of the Fallopian tubes.

The limits of this paper will not permit a discussion of the diagnosis of diseases of the Fallopian tubes, but when such a disease of the tube or tubes is clearly diagnosticated, then, and only then, in my opinion, is the use of the intrauterine sound contradicted in retroversion or retroflexion of the uterus.

Since the Fallopian tubes are a continuation of the uterine canal, and similar in structure, any irritating matter contained therein is

liable to be forced outward into the peritoneal cavity, by any wave of contraction commencing in the uterus and extending to the tube, from whatever cause, whether it be the introduction of a sound, violent exercise, sudden pelvic congestion, or the sexual act. It is admitted that the objections of Emmet and his followers to the use of the sound are, to a certain extent, logical, but it is also claimed,—first, that those objections apply only to cases complicated by pus in the Fallopian tubes; and second, that the same objections apply with equal, if not greater force, to any other form of treatment in the same condition.

636 SUTTER STREET.

Society Proceedings.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, September 9, 1891.

THE President, JOHN B. ROBERTS, M. D., in the Chair.

Dr. EDWARD JACKSON read a paper on

AN OPHTHALMOSCOPE FOR GENERAL USE.

It would be a great gain to both doctors and patients if a much larger proportion of those who class themselves as general practitioners were able, when the need for it arose, to use the ophthalmoscope. One who has no practical experience with it cannot even properly appreciate what he reads or hears of ophthalmoscopic appearances. And there are in the aggregate many cases in which the progress of general disease could be far more intelligently followed by its routine use, without entering upon debatable ground or attempting to use symptoms of doubtful significance.

With the ophthalmoscope, as with other instruments, the cheap instrument is very apt to lack certain important features, and the costly instrument is mainly confined to the possession of those who mean to use it a good deal. It took many years to adapt the microscope to the needs of clinical work, to rid it of mechanical stages and other mechanical nuisances, and perfect its really essential parts. And the ophthalmoscope must pass through a similar pruning and adaptation before its use can be truly popular and common in the

profession. For some years I have been working at this problem, and herewith present my results.

The ophthalmoscope for general use must: First, be one in which the difficulties of using the instrument are, as far as possible, overcome. Second, it must be one that will be as satisfactory as any of the best instruments for any case that is likely to be encountered. Third, it must be cheap. For this one I have no hesitation in claiming that with it the fundus of the eye can be seen as readily as with any ophthalmoscope heretofore made; for all practical purposes as a refraction ophthalmoscope, its lens series is complete; it can be bought for eight dollars.

It is easy to see through, because the mirror, which is circular, 30 mm. in diameter, tilts each way to the best angle, at about 25 or 30 degrees; it has a shorter canal and wider lenses than have most first-class refraction ophthalmoscopes; each lens is retained in exact position by a spring stop; and all the lenses or combinations of lenses are available without taking the instrument from the eye.

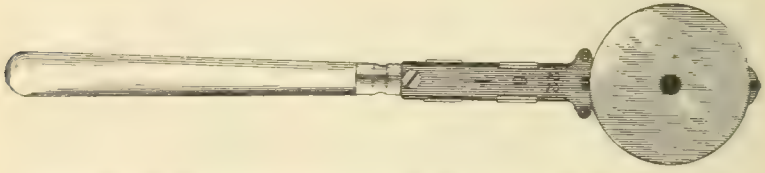
The lens series is furnished by combinations of six lenses in two slides, and consists of convex 1, 2, 3, 4, 6, and 12 dioptres; concave 1, 2, 4, 6, 10, and 22 dioptres. To appreciate this series, one must bear in mind the degrees of ametropia that are commonly encountered in practice. Among 4,000 eyes, the statistics of which I have published in the *Transactions of the American Ophthalmological Society* for 1889, only one eye had hyperopia of 13 dioptres, and only one eye had myopia of 23 dioptres.

The series does not contain half-dioptres, which are given in all the larger refraction ophthalmoscopes; but a very prominent ophthalmologist has recently said that he had the half-dioptre lenses taken out of his large instrument (Noyes's modification of Loring's) as comparatively worthless. Under especially favorable conditions there are a few ophthalmoscopists who have constant and extensive practice with the instrument who can, I believe, measure refraction with a little more exactness with half-dioptre lenses than they could with only whole-dioptre intervals. But the ophthalmoscopists that can do this are comparatively few, the cases in which they can do it are few, and the practical value of doing it is utterly insignificant. For those who are not in special practice half-dioptre intervals are always a delusion and snare, a hindrance, a cause of inaccuracy. They are, therefore, discarded.

Although the statistics above referred to show that in but one eye in forty of those encountered in practice is the degree of ame-

tropia over 6 dioptres, to one not very familiar with the properties of lenses the intervals between the stronger lenses of this series may seem too great. Such must be reminded that the effect of every intermediate lens strength may be obtained by slightly varying the distance of the lens and instrument from the patient's eye. Thus the convex 6-dioptre lens acts as such only when placed against the eye: by drawing it back less than three inches it is made to act as a 12-dioptre lens, and within that space will correct any intermediate amount of hyperopia. By withdrawing the 12-dioptre convex lens a little over one inch, it takes the place of a 20-dioptre lens. On the other hand, by withdrawing the concave 22-dioptre lens a little over two inches, its effect is diminished to 10 dioptres, and in that space every intermediate strength is reproduced. In the same way, the withdrawal of the 10-dioptre concave lens to the same distance gives us the 6-dioptre effect.

When this is remembered, it is readily seen that any measurement of refraction by strong lenses is utterly untrustworthy unless the distance of the lens from the eye is taken into account; and if it is taken into account, any additional intermediate lenses are quite unnecessary. The above series is sufficient for the direct method in all cases except the very highest myopia, for which the expert ophthalmoscopist is apt to resort to the indirect method as more satisfactory.



To one accustomed to using a disc ophthalmoscope, the arrangement of lenses as here, in slides, will at first seem awkward and confusing, but to one who begins with this instrument, or who has already used an instrument in which the lenses are so placed, it is especially convenient. The convex lenses are all in the back slide, the concaves in the front. One can be used alone, or both slides can be moved at once by the tip of the same forefinger, according to the lens required.

In the focus of the mirror, the size of the sight hole, the blacking of it, the proportioning of the instrument, and its mechanical execution, it is equal to the best ophthalmoscopes now used. It is made by Mr. D. V. Brown, of Philadelphia.

Since this is not my first attempt at the modification of the ophthalmoscope, and another instrument has my name associated with it, perhaps it will prevent confusion if I exercise the right of naming this. And with the idea of giving it a name that shall by a single word indicate the idea of its design for general use, I shall call it the Polyclinic Ophthalmoscope.

SWEET OIL IN THE TREATMENT OF GALL-STONES.

A COLLECTIVE INVESTIGATION BY THE THERAPEUTIC SECTION OF THE PHILADELPHIA POLYCLINIC MEDICAL SOCIETY.

BY THOMAS J. MAYS, M. D.

The subject of the action of sweet oil in the treatment of biliary colic and catarrh of the hepatic passages has recently been warmly discussed. There are many who regard this agent as being very much overrated, while many others believe that it has a very beneficial influence on this disease. In view of the divided opinions on, and the importance of, this matter, the Therapeutic Section of the Philadelphia Polyclinic Medical Society has, as a part of its scientific work, undertaken a special collective investigation concerning the clinical value of this drug in gall-stone colic. With this end in view, the undersigned committee was appointed, and directed to send a number of circulars to the members of the profession, of which the following is a copy :

Sex and age of patient ? Seat of pain ? Jaundice ? Previous attacks ? Did you test any other remedy, and with what results ? Result of treatment with olive oil. Remarks.

To these circulars nineteen replies were received, and thirty-seven cases of gall-stone colic treated with olive oil were reported. To these members of the profession the warmest thanks of this committee are due for the promptitude with which they responded. Additionally the committee imposed the task upon itself to collect, as far as possible, all the previously reported cases of biliary colic which were treated according to this method, and succeeded in gathering records of seventeen cases, making altogether a list of fifty-four cases, a condensed history of which is presented in the following table :

1. Read September 9, 1891.

Table of Cases.

No.	Sex and age.	Seat of pain.	Jaundice.	Previous attacks.	Use of other remedies, and results obtained.	Results obtained from the use of sweet oil	Remarks.	Name and address of observer.
1	F. 40	Right hypochondrium.	Yes.	Three or four.	None.	Six ounces taken in 3 hours. Relief in twenty-four hours.	No recurrence for more than 3 years, up to time of report.	H. T. Bahnson, Salem, N. C.
2	M. 50	Right hypochondrium.	Yes.	A great many.	Antipyrin hypodermically, with temporary relief.	One pint taken in two hours; complete relief.	No return for more than 2 years.	H. T. Bahnson, Salem, N. C.
3	F. 65	Right hypochondrium.	Yes.	Five or six.	None.	Half a pint taken in four hours; relief in 12 hours	No return for more than 3 years. In two other cases the single large dose produced relief, but failed to prevent a recurrence of attacks.	H. T. Bahnson, Salem, N. C.
4	M. 46	Right hypochondrium.	Yes.	Three.	Chelidonium and dioscorea gave some relief.	Quantity of oil given not stated. Remained well so long as he took it.	Used it in other cases of biliary troubles, and with good success.	G. R. Fortiner, Camden, N. J.
5	M. 34	Right hypochondrium.	Yes.	No.	Chelidonium without relief.	Quantity of oil given not stated. Administered it for 10 days, when patient died.	*Post-mortem* investigation showed complete adhesive obstruction of bile ducts. Patient received a blow in hepatic region some time before.	G. R. Fortiner, Camden, N. J.
6	F. 28	Gastric region.	Yes.	Eight or ten.	Sodium phosphate without benefit.	One pint at a single dose. Complete relief.	No recurrence within a year.	J. J. Cox, High Point, N. C.
7	F. 49	Epigastrium.	Yes.	Six.	Sodium phosphate with some benefit.	Took the oil for 4 weeks. Dose not stated.	No recurrence; general condition much improved.	G. H. Franklin, Hightstown, N. J.
8	M. 67	Epigastrium.	Yes.	Twelve	Sodium phosphate, after which a severe attack became less frequent.	Continued oil for 6 weeks. Dose not given.	No recurrence; improvement after oil surprising.	G. H. Franklin, Hightstown, N. J.
9	M. 45	Right hypochondrium.	No.	One a week for 3 months	None.	Took the oil for 4 weeks. Dose not given.	One light attack since he began the oil.	G. H. Franklin, Hightstown, N. J.
10	M. 31	Right hypochondrium.	Yes.	Once every 3 weeks during 14 years	Morphine and anesthetics; temporary abatement.	Dose of oil not stated. Free from attacks for 11 months.	Her previous sufferings were intense, requiring large doses of narcotics.	A. B. Glonnger, Lebanon, Pa.
11	F. 35	Right hypochondrium.	Yes.	Uncertain.	None.	Dessertspoonful of oil every 3 hours. Relieved after second dose.	History of malaria, liver and spleen enlarged.	E. Lawney, Denver, Col.
12	M. 10	Right hypochondrium.	Yes.	One 5 years before.	None.	Dessertspoonful of oil. Pain relieved at once.	Also gave ammon. chloride, gr. iij., and calomel 1-32 gr. t. i. d	E. Lawney, Denver, Col.
13	F. 51	Hepatic and gastric region.	Yes.	No.	Yes; nature of same not mentioned.	Daily for 2 days gave 8 ounces of oil; no relief.	Patient died.	E. P. Bernardy, Philadelphia.
14	F. 72	Region of gall-bladder.	Yes.	No.	Yes; nature of same not mentioned; no benefit.	Nine ounces of oil for 10 days without positive improvement.	Oil caused numerous alvine discharges, lightened the color of skin, and seemed to reduce size of gall bladder.	E. P. Bernardy, Philadelphia.

TABLE OF CASES.— *Continued.*

No.	Sex and age.	Seat of pain.	Jaundice.	Previous attacks.	Use of other remedies, and results obtained.	Results obtained from the use of sweet oil	Remarks.	Name and address of observer.
15	M. 40	Right hypochondrium.	Yes.	Several but none for 5 years.	Dioscorea, morphine, and atropine, with some relief	Dessertspoonful every half hour with the most marked relief.	Regulated diet, and gave sodium phosphate, etc.	Theo. G. Davis, Bridgeton, N. J.
16	F. 30	Over abdomen.	Yes.	One, possibly two	Calomel, sol. bicarb., and morphine slight relief.	Dessertspoonful of oil every 3 hours; complete relief after second dose.	Stools contained concretions.	E. H. Bidwell, Vineland, N. J.
17	F. 55	Right hypogastrium.	Yes.	Yes.	Morphine and atropine hypodermically, with what results not stated.	Gave 6 ounces of oil, and relief came in an hour. Following day slight attack, 10 ounces. No recurrence.	The intense vomiting from which she suffered ceased after the oil was taken.	Ch. Pottberg, Philadelphia.
18	M. 40	Right hypochondrium.	Yes.	Several	Silver nitrate, regulation of diet and water with good results.	Dose of oil not stated. Negative results.	Examination of feces after oil showed contents of soapy concretions	J. Dolan.
19	M. 50	Right side of abdomen	Yes.	At least two.	Chloroform inhalation and sodium bromide; did not obtain decided relief until oil was taken.	Relieved after taking 3 doses (size not stated) of oil	The oil appeared to relieve him, but he may also have been helped by the chloroform.	
20	M. 46	Over gall-bladder on pressure.	Yes.	Two.	Not stated.	Ten hours after taking 1 quart of oil in divided doses, 2 large gall-stones discharged in the stools. Steady improvement.	Bowels had not been moved for 4 days before the oil was taken. Singultus existed for 12 hours before bowels moved.	A. F. Magruder, U. S. N., Wash. D. C.
21	M. 52	Over gall-bladder.	Yes.	For years at intervals of from 4 to 6 months	Nature of, not stated, temporary relief.	Half-ounce doses of oil every 5 hours for about a month before report was made.	Too early to judge the effect of oil. General health better than for two months.	J. D. Dewitt.
22	F. 40	Right hypochondrium.	Yes.	One about 2 months before.	Morphine, quinine, atropine, calomel, etc. Not the prompt relief obtained with the oil.	Dessertspoonful of oil every 4 hours. Improvement at once.	No recurrence so far as known. Gall-bladder diminished in size.	Thos. J. Mays, Philadelphia.
23	F. 45	Right hypochondrium.	Yes.	Periodically for a number of years.	Morphine and atropine hypodermically gave slight temporary relief.	Dessertspoonful of oil every 3 hours, with decided relief.	No attack since so far as known.	Thos. J. Mays, Philadelphia.
24	M. 20	Not known.	Yes.	During previous 3 months	No.	Dessertspoonful of oil 3 times a day with prompt relief	No return so far as can be learned.	Thos. J. Mays Philadelphia.
25	M. 27	Right hypochondrium.	Yes.	Periodical during previous year.	Not by observer.	Dessertspoonful of oil 4 times a day with gradual relief.	No recurrence.	Thos. J. Mays, Philadelphia.
26	M. 67	Right hypochondrium.	No.	No.	None used.	Dose of oil not given. Complete relief.	Hard concretions like gall-stones passed freely for 10 days after taking the oil.	C. R. Early, Ridgway, Pa.
27	F. 35	Right hypochondrium.	Yes.	Very frequent.	Morphine, mercury, and potassium iodide; good results.	Dose of oil not stated. Good results.	Perfectly well in 3 or 4 weeks after taking the oil.	C. R. Early, Ridgway, Pa.

TABLE OF CASES.—*Continued.*

No.	Sex and age	Seat of pain.	Jaundice.	Previous attacks.	Use of other remedies, and results obtained.	Results obtained from the use of sweet oil.	Remarks.	Name and address of observer.
28	M. 23	Right hypochondrium.	Yes.	Yes.	Potassium chlorate, sodium bi-carbonate, and ipecac; good results.	Dose of oil not stated. Cured in 2 weeks.	No recurrence for 3 years.	C. R. Early, Ridgway, Pa.
29	F. 50	Right hypochondrium.	Yes.	Yes.	None by observer, but by other physicians.	Dose of oil not stated. Found relief in 2 days.	No recurrence; treated 40 years ago. Treated many similar cases during this time.	C. R. Early, Ridgway, Pa.
30	F. 54	Right hypochondrium.	Yes.	Quite a number.	Of everything else he tested, chloroform seemed to give the best results; relief temporary.	Six ounces of oil in 2 equally divided doses, half an hour apart. Gave oil at 3 different times. No symptoms for 2 years.	Passed a large number of calculi. Enforces a rigid dietary in all these cases. Allows no sugar starchy or fatty foods.	D. P. Boyer, Philadelphia.
31	M. 60	Right hypochondrium.	Yes.	A number during 3 previous years.	Sodium phosphate, chloroform, morphine, and succinic acid; no satisfactory results.	Same dose as in previous case. Relieved 2 attacks 2 months apart.	No recurrence since second attack, which occurred a year and a half ago.	D. P. Boyer, Philadelphia.
32	F. 22	Right hypochondrium.	Yes.	Two.	Sodium phosphate, morphine, mineral water, etc., seemed to relieve first, but not second attack.	Only received the oil for 2 days, when she was entirely relieved. Passed a number of calculi.	Treated about 10 cases with the oil, and in all there was either a cure or benefit.	D. P. Boyer, Philadelphia.
33	M. 42	Right hypochondrium and in epigastrium.	Yes.	None.	Tested numerous cholagogues without benefit.	Six ounces of oil at night, followed next morning with laxative; relief.	Discharge of biliary calculi. No recurrence.	Ed. R. Mayer, Wilkesbarre, Pa.
34	F. 40	Right hypochondrium.	Yes.	About 2 a year for 15 years.	Not by observer.	Six ounces of the oil gave prompt relief. This was the last attack the patient had.	Insists on a rigid dietary. Cholagogues, Carlsbad waters, etc., as preventatives.	Ed. R. Mayer, Wilkesbarre, Pa.
35	M. 58	Right hypochondrium and right shoulder.	Yes.	No.	Not by observer.	Same dose of oil in the evening and purgative in the morning. Complete relief after 4th dose. No recurrence.	Gall-bladder was so distended with calculi that it could easily be mapped out. Treated about 35 cases of gall-stones during last 14 years with olive oil, and in every instance the severity of the attack was mitigated by the first and entirely relieved by third or fourth dose.	Ed. R. Mayer, Wilkesbarre, Pa.
36	F. 42	Right hypochondrium and back.	Yes.	Suffered for 10 years off and on.	Sodium phosphate gave temporary but no permanent relief like the oil.	Tablespconful of oil every 3 hours for about 1 month; after an interval gave it again, but less frequently. Pain ceased at once after oil was administered.	No recurrence; passed a calculus in feces weighing 40 grs.	J. S. Baer, Camden, N. J.

TABLE OF CASES.—*Continued.*

No.	Sex and age.	Seat of pain.	Jaundice.	Previous attacks.	Use of other remedies and results obtained.	Results obtained from the use of sweet oil.	Remarks.	Name and address of observer.
37	M. 68	Epigastrium and right hypochondrium.	Yes.	Two.	Opium and ether only gave temporary relief.	Dessertspoonful doses of the oil gave prompt and decided relief.	No recurrence.	H. C. Bloom, Philadelphia.
38	F. 42	Region of gall-bladder.	Yes.	Yes.	Morphine hypodermically and by the mouth; ether inhalation and hot poultices, without relief.	Half an hour after swallowing from half to three-fourths of a pint of oil the pain ceased abruptly.	First 3 passages after oil contained 2 gall-stones; has had 2 slight attacks, since which did not require medical interference.	D. D. Stewart, Med. News, Nov. 23, 1889.
39	F. 15	Right hypochondrium.	Yes.	Yes, for 12 years.	Morphine and atropine hypodermically, hot water, etc., relief for 2 hours when pain returned as severely as before; morphine gave no relief.	Forty-five minutes after being able to retain 5 ounces of *linseed* oil pain diminished, and ceased 3 hours later.	Subsequent attack, same as relieved by the oil. Fifth day after last attack passed a gall-stone as large as a beech nut.	D. D. Stewart, Med. News, Nov. 23, 1889.
40	M. elderly.	...	Yes.	For some years.	Usual remedies, without relief.	Six ounces of oil at bedtime, followed by castor oil next morning. Passage of gall-stones. Relief.	In 2 days another paroxysm of pain was threatened. Ordered oil 2 following nights. Saw her four months after. No recurrence.	R. Kennedy, Kingston, Can. Lancet, 1890, vol. ii., p. 456.
41	F. adult	...	..	For years.	Not stated.	Full doses of oil for 2 consecutive days. No return.	Passed a large number of calculi. Relieved two other cases of gall-stone colic with the oil.	R. Kennedy, Kingston, Can. Lancet, 1890, vol. ii., p. 456.
42	F. 40	.....		Yes.	Treated by other physicians without relief.	Eight ounces of oil at bedtime and following morning after last a dose of castor oil. Relief.	Evacuated several small gall-stones.	Dr. Gay, Buffalo, Buff. Med. and Surg. Journ., vol. vi., p. 214. 1866–67.
43	M. adult	....	.	Third attack.	Morphine hypodermically to allay pain.	Eight ounces of oil night and morning, followed by a dose of podophyllin. Relief.	Says that olive oil is as much a specific in gall-stone colic as sulphur is in scabies.	Dr. Gay, Buffalo, Buff. Med. and Surg. Journ., vol. vi., p. 214. 1866–67.
44	F. adult	Pain in epigastrium.	Yes.	Yes.	Was treated for scirrhus of the liver by other physicians. Received 60 drops of McMunn's elixir of opium, with only temporary benefit.	Eight ounces of oil for 2 consecutive nights. Evacuated calculi. Relief.	Success in this case led him to use it in another, which is not fully described.	Ira Hatch, Chicago, Ill. Chicago Med. Examiner, 1867, vol. viii., p. 469.
45	... adult	...	.	At least one attack before.	One-eighth gr doses of calomel; bowels moved; no relief; patient vomited everything.	Two pints of oil in divided doses. Relief. The oil was the only thing which would remain in stomach.	An operation had been suggested, but with the improvement it was abandoned.	F. W. Langdon, Cin. Lancet-Clinic, 1890, p. 191.

TABLE OF CASES.—*Continued.*

No.	Sex and age.	Seat of pain.	Jaundice.	Previous attacks.	Use of other remedies, and results obtained.	Results obtained from the use of sweet oil.	Remarks.	Name and address of observer.
46	F. 36	Liver enlarged and sensitive; gall-bladder enlarged.	...	Almost daily for 5 years.	Obtained no relief from other treatment.	Large doses of oil for 2 weeks. Relief.	Free from attacks for 18 months, up to the time report is made. Passed hard concretions.	S. Rosenberg, Therapeut. Monatshefte Dec., 1889, vol. iii.
47	F. 37	In hepatic region; enlarged liver.	Yes	At least for 5 months attacks occ'rr'd during menstrual periods.	Cathartics and other agents brought no relief.	Twenty-four hours after the first large dose of oil pain disappeared, and in a few days the liver diminished in size.	About 2 months after this attack there was a slight return checked with 1 dose. No recurrence and a general improvement.	S. Rosenberg, Ibid.
48	F. 38	.....	...	For 9 years; latterly once a week.	Mineral-water cure without benefit.	Large doses of oil relieved her, excepting a slight soreness in region of liver, which was cured with 15 grs. sodium salicylate 3 times a day.	Passed a biliary calculus. Free from pain to time of the report about one year.	S. Rosenberg, Ibid.
49	F. 48	In region of gall-bladder.	Yes.	Several attacks.	.....	Large doses of oil followed by 2 passages and relief within 24 hours.	Passed large number of concretions. The attack occurred with each menstrual period for some time before she took the oil.	MM. Chauffard et Dupré. Société Médicale des Hôp. de Paris, tom v., 1888.
50	F. 62	.....	Yes.	For 12 years.	.....	Large dose relieved her for 8 days, but the final results are of a doubtful character.	....	MM. Chauffard et Dupre. Ibid.
51	F. 50	.....	Yes.	For a number of years.	.....	Large doses of oil were followed by local and general improvement.	.....	MM. Chauffard et Dupré, Ibid.
52	F. 45	In hepatic region.	Yes.	At least 3 attacks.	.....	Large doses of oil followed by beneficial results.	The pain in the hepatic region disappeared, and the colic was cured.	MM. Chauffard et Dupré, Ibid.
53	F. 58	In hepatic region.	Yes.	A number of attacks.	.....	Large doses of oil followed by relief.	Passed a large number of concretions. Pain and swelling in liver disappeared.	MM. Chauffard et Dupré, Ibid.
54	F. 43	In hepatic region.	Yes.	Six attacks.	.....	Large doses of oil followed by relief.	The attacks of biliary colic were associated with nephritic colic, and with the discharge of a urinary calculus, biliary calculi passed at the same time	MM. Chauffard et Dupré, Ibid.

An analysis of these fifty-four cases shows that there were about one-third more females than males who suffered from gall-stone colic; that two died, that in three negative results were obtained, and that in fifty, or in ninety-eight per cent., positive relief was afforded. These results make a better showing still, when we consider that one of those who died was suffering from adhesive obstruction of the bile-duct — a disease which no procedure, either medical or surgical, could have remedied. Nor do these figures give us a true estimate of the favorable action of olive oil in this disease; for two of the observers state that they have treated forty other cases of biliary colic without a failure, but of which they had kept no record — making in all a collective return of eighty-nine cases — showing the great value of this drug.

These cases illustrate, then, the positive efficaciousness of sweet oil in the treatment of gall-stone colic, and the question naturally arises, therefore, as to the manner in which this agent acts. Dr. Rosenberg's experiments ("Ueber die Anwendung des Olivenöls bei der Behandlung der Gallensteinkrankheit," *Therapeutische Monatshefte*, December, 1889, S. 542,) demonstrate beyond a doubt that it largely increases the quantity of bile secreted, while at the same time it diminishes its consistency. But how does it accomplish this? Does it stimulate the biliary channels by coming in contact with their openings into the alimentary canal? Or is it decomposed into fatty acids and glycerin through the instrumentality of the pancreatic juice, and does the "glycerin so liberated exert in the duodenum an action similar to that which takes place when it is introduced into the rectum," causing a powerful reflex peristalsis — an ingenious theory suggested by Dr. D. D. Stewart?[1] Or does it act in accordance with the hypothesis formulated by Virchow, who shows from his own experiments (*Therapeutisch Monatshefte*, 1890, S. 86,) that it is absorbed from the alimentary canal, is excreated by the liver, and is thrown into the bowels again through the biliary passages? The last of these theories appears to be most rational, because it explains certain well-known features in its action, and also places it on a level with the action of other cholagogues. We may conceive, then, that the beneficial influence of oil consists not so much in dissolving the biliary concrements, as it does in increasing the biliary excretion, in flushing, and in lubricating and washing out the passages of the liver.

1. A Suggestion as to the Action of Olive or Cotton-Seed Oil in Gall-Stone Colic. By Dr. D. D. Stewart. *Medical News*, November 23, 1889.

Another point of interest in this collection is as to the proper dose of the oil. Are the large doses necessary which were administered to most of the cases in this collection? It appears not, for eight of the cases (Nos. 11, 12, 15, 16, 22, 23, 24, and 25,) received only dessertspoonful doses every three or four hours, and apparently with the same prompt and positive relief as that which was afforded by doses of from five ounces to one and two pints. If this should be confirmed by further experience, it would be a great practical gain, in view of the fact that a great many persons show a strong aversion to all kinds of oil, especially if they are to be taken in large quantities.

Furthermore, according to the observation of Dr. Stewart (Case 37,) it does not appear to make any difference whether olive or cotton-seed oil is used. Indeed, it is well known that much of the oil which is sold as olive is in reality refined cotton-seed oil; and Dr. Stewart's observation tends to show that in all probability any bland oil will have the same effect on the disease under consideration.

In conclusion, the committee desires to congratulate the Polyclinic Medical Society on the selection of a subject for collective investigation which has proven so fruitful of practical results as that which is embodied in this report; and expresses the hope that it may continue its good work of testing therapeutic agents in a clinical way. It is true that animal experimentation often points out the path in which the usefulness of a drug lies, but clinical and collective research is, after all, the crucial and final test of all true therapeutic progress.

Thomas J. Mays, M. D.,
Homer C. Bloom, M. D.,
Committee.

DISCUSSION.

Dr. William S. Stewart: I wish to show the society a stone which was obtained this summer from a lady between seventy and eighty years of age. She had suffered with periodical attacks affecting the bowels and passing off with simple treatment. On the last occasion she suffered excruciating pain in the region of the cecum, and I was sent for. Thinking there might be some inflammatory affection in this region and that possibly abdominal section would be necessary, and finding a mass in the right iliac region, I placed her in the knee-chest position and gave her a very large injection. After as much as possible had been injected, I had her sit on a jar. Not experiencing relief, I continued the injections while she was in

this position, using flaxseed tea. This was continued for five or ten minutes. She was then put to bed and another large injection given. I then left her, and shortly afterward she got up and this huge gall-stone was passed. (About the size of a hen's egg.)

Some twenty-five years ago my attention was directed to the method of treatment by olive oil by a lady from California. I had seen her some time before in a debilitated condition from frequent attacks of biliary colic. I inquired the cause of the improvement, and she told me that she went with a friend to see a quack, who at once told her that she had gall-stones, and directed her to take half a pint of sweet oil in the evening, and to rub the right side frequently during the night, telling her that when her bowels were opened she would pass many gall-stones. It happened just as he said, and she had entire relief. Since then I have taken advantage of this hint.

I use the spirits of chloroform in combination with olive oil during the period of attack, and recommend that the oil be continued in doses of two tablespoonfuls before each meal, for a period of several weeks afterward. In this connection I recall to mind an amusing occurrence that happened in the army. A soldier was suddenly taken with biliary colic, and the assistant surgeon, an ignorant man, who had been promoted from the position of hospital steward, was called. He at once prepared a dose of chloroform, and taking it to the patient, said: "Take this; it may do you good or it may kill you; try it."

Dr. John C. DaCosta: My results with olive oil have not been so brilliant nor so quick as those reported in the paper. Opiates and chloroform will relieve the pain, but phosphate of soda does not seem to act as well as reported. Calomel between the attacks acts well; corrosive sublimate still better. One case will illustrate what I have to say. A hysterical woman has had at least five or six attacks in two years. I was disposed to think that all the attacks were not due to gall-stones until she brought me the stones which she had just passed. She was treated with olive oil in half-pint doses. Since then she has had four or five attacks. In the last two she did not consult me until they were over. She takes half a pint to a pint of olive oil at one dose and lies down. In twelve or fourteen hours (not two or three as in some of the reported cases) she is relieved. The oil seems rather to lengthen the interval between the attacks.

Dr. M. Price: The committee deserves great credit for its thorough investigation, but I cannot see the brilliant results referred to.

In my experience I have not found the spasm of biliary colic to last many hours. How olive oil can relieve the pain, unless it is by a lubricating process, I cannot understand. Many stones are of a soft non-irritating nature : and if the spasm in the gall-duct is relieved, there is no trouble ; the stone passes readily except when the duct is inflamed. Within a month I have seen two post-mortems. In one, a man, there were found two hundred and fifty gall-stones in the bladder. The man had never had an attack. In the other, that of an old lady with cancer of the kidney and a stone in the kidney, the gall-bladder contained five or six ounces of grumous fluid and a number of soft gelatinous stones. She had never had any symptoms referable to the gall-bladder. There is another form of stone in which the treatment could be of no benefit, and that is in those hard ones which we see in cancer, and which in many cases, I think, are the cause of cancer of the liver. Where the stone is large and produces constant irritation there can be no possible benefit from any treatment except tremendous doses of morphia. The stones which I show you are hard and were removed by section.

The history of the cases reported is of this character. You prescribe a remedy to which the patient submits and endures the pain until the spasmodic period of the disease passes. Chloroform and morphia during the continuance of the spasm seems to be the only rational treatment.

In this whole series of cases has there been a post-mortem ? It is very difficult to say when you have a patient suffering with spasmodic pain in the region of the gall-bladder that it is due to gall-stones. Four or five years ago I saw a traveling minstrel who had had attack after attack, and had been treated by the best surgeons in the country for gall-stones. He had received olive oil and many other methods of treatment. I said to him there was no use of doing anything until we found out what was in the gall-bladder. I operated, and after breaking up adhesions reached the gall-bladder and found it perfectly healthy. The patient was completely relieved. His symptoms had simulated gall-stones so much that many surgeons wanted to open him for gall-stones.

In regard to cases of obstruction of the gall-duct.[3] There are cases simulating gall-stones which are not relieved by medical treatment, but which could be relieved without trouble by abdominal section. It has been suggested by one of the best surgeons in this

3. In the doctor's report of the case of stricture of the gall-duct with death, the post mortem found no stone ; in this case it was stricture, and not stone, under treatment.

country to open the abdominal cavity and drain the gall-bladder, then to take a rubber ligature and unite the duodenum or ileum to the gall-bladder, and then with a whipped suture unite the peritoneum of the bowel to the peritoneum of the gall-bladder. In the course of three or four days a fistula forms and then the abdominal opening can be closed with silkworm gut sutures, previously introduced. There is no question that gall-stones of the size that I have shown should be removed. It is my firm belief that gall-stones of this hard, irritating nature may in time produce malignant disease of the gall-bladder or of the gall-duct.

I think with Dr. Mays, that the explanation of the benefit of olive oil, if it exerts any, is to be found in the lubricating and stimulating qualities of the oil, and that it relieves spasm simply by its purgative effect. I cannot see otherwise where the benefit can come in. It has no solvent effect, and it cannot remove a stone whose diameter is ten times that of the gall-duct.

Dr. James B. Walker: In my experience, the question is not so much what will relieve the attack, as what will prevent its recurrence. If one would send out a series of questions in regard to the usefulness of any particular agent in gall-stones, would he not receive replies very similar to those given tonight? Take calomel, or any other agent which acts as a laxative, and it will terminate an attack of gall-stones, if it is a terminable attack. The question is, what will prevent recurrence? So far as this report goes, it seems to give to olive oil a favorable position as an agent for preventing recurrence. This is the most favorable report that I have seen. Still these are not exceptional results. We meet with cases of gall-stones where the attack is never repeated. Unquestionably, in many cases, the recurrences are due to the number of gall-stones. Sometimes, however, the attack terminates without the discharge of the stone, and yet there is no recurrence for months. I have a patient who recently passed a calculus, resembling a mulberry, both in shape and appearance; he passed this after a number of attacks under my observation. The attacks were treated with morphia and calomel, followed by phosphate of sodium and nitro-muriatic acid. After each attack there would be a return to health for a period. In at least ten attacks, the feces were examined without result. At times a detritus was found, looking like a crumbled stone. This was found in the last attack, and it was thought that the stone had crumbled and passed; however, the following day another severe attack occurred, in which blood was passed, and in the center of a

clot of blood was found the calculus, as large as the last joint of the index finger, and without facets. This was, unquestionably, the cause of all the trouble.

I believe that any laxative agent which will promote peristalsis and free biliary discharge will relieve the immediate attack if the stone can escape; then some agent to relieve the catarrh of the duodenum and the hepatic catarrh will be required. I have used olive oil in several cases, but my experience has not been satisfactory. The case just referred to received six ounces of olive oil on two occasions without benefit; other patients have received equal doses without success. The best remedy that I have found for old, recurring cases, where there seems to be an impacted stone, and where even cancer has been suspected, from the cachexia, is spirits of chloroform. In two cases, sisters, seen at intervals of five years, this seemed to be the agent that turned the tide of events after repeated efforts with other remedies. I gave it in teaspoonful doses three times a day. The cases immediately changed their character, the jaundice disappeared, and improvement in the general health took place. I believe the chloroform, which is known to increase the liquefaction of the bile, is of value in these cases; this, with phosphate of sodium, or some other sodium salt, or, where the patient is wealthy enough, a visit to the Carlsbad Springs. Here the waters are taken with a strict dietary for three weeks; when the patient is emaciated to a certain degree, he is sent to some other place for recuperation, to return for three successive years. This will often effect a cure. I have a patient who has been benefited by this course. After her return from the first visit to Carlsbad she had three attacks during the year; after the second she had two, and her general health was excellent. She is now returning from her third visit.

Dr. Streets, of the navy, has mentioned to me an interesting case where he used olive oil. The patient, a sailor, was seized with an attack of gall-stones, and was at once put upon the use of olive oil. The discharges were saved, and there were obtained a number of soft, pulpy bodies, which had a very odd appearance. They were somewhat globular, and not faceted. These were placed on a surface so that the oil could be absorbed, and they shrunk in size, showing them to be faceted gall-stones. It seemed as though the oil had penetrated these in some way, either before or after leaving the biliary duct. They were, unquestionably, gall-stones.

Dr. A. B. Hirsh: There is possibly one class of cases in which

exception might be taken to Dr. Price's remarks in regard to having a remedy that would obviate future attacks, that is, those cases of distortion of the anatomy of the parts where no operation would avail. In the majority of cases of cholecystotomy we allow for drainage for some time, in the hope that the habit of inspissation of bile may be overcome. Those cases in which peritonitis is associated with resulting obstructive bands, and where, after closure of the fistula the symptoms recur, are not satisfactory ones to deal with. I have met with several such cases, and in these any remedy that offers a promise even of relief should be welcomed.

In regard to the cases reported by practitioners who see but few, and then only at long intervals, there often remains some doubt as to the correctness of their diagnosis. Dr. Porter published in the St. Louis *Weekly Medical Review*, in the Spring of 1889, a paper in which he analyzed a large number of such cases reported of supposed relief of gall-stones by the use of olive oil: he appeared to show that the treatment had no scientific basis: that the cases had not been followed sufficiently long, and that, if anything, the observers had been careless in taking notes.

Dr. Mays: I am here, perhaps, as the innocent champion of olive oil in the treatment of this disease. Having had some very favorable results from its action in three cases of gall-stones, I proposed the subject to the Polyclinic Medical Society for further investigation. From my own experience with it, I think that we ought to be very careful and not make any dogmatic statements concerning the action of this oil. Even if we do not know how an agent acts, we are warranted in ascribing some usefulness to it, if it does the work which was intended it should perform, and especially if we were unable to accomplish this with anything else. I believe the cholagogue action of olive oil has been denied this evening, and in answer to this I would say that Rosenberg's experiments, which show its powerful influence on the biliary secretion, have been before the profession for at least a year and a half. Rutherford found that sodium salicylate was one of the best cholagogues, but the former demonstrated that the olive oil excelled the latter agent as a biliary stimulant. In view of this influence, it is easy to see how it acts in this disease, and it is also easy to see how the sodium salicylate acts beneficially in similar cases.

Dr. Price seems inclined to doubt that the concretions, which are evacuated after the oil is administered, are true gall-stones. This is, of course, difficult to determine in many of the cases which

are reported, but at least in one instance (Dr. D. D. Stewart's case) the concretions were examined by Dr. Leffmann, and by him pronounced true gall-stones.

I can hardly agree with the opinion of Dr. Walker that the sending out of inquiries concerning the action of any agent in biliary colic would have brought similar favorable replies. There is too much unanimity, I may say, in the reports favorable to the action of the oil to give the least countenance to such a belief. Besides, we endeavored to guard against this very uncertainty. The circular asked expressly whether any other agents had been given, and with what results. In the great majority of cases all the known remedies had been tried, with doubtful results, or with failures. Many observers stated that no agents had given such signal relief as sweet oil.

If we believe in the efficacy of cholagogues to relieve the attacks of biliary colic, and are in search of an agent having a similar action to prevent their recurrence, then, I think, it is useless to advocate the action of chloroform in this disease, as has been done tonight. So far as I know, chloroform is not a cholagogue, but may act by relieving the spasm of the gall-ducts, and by having a solvent action on the calculi. I can more readily see how olive oil would prevent such recurrence, since it is one of the best stimulants to the hepatic secretion that we possess.

AMERICAN ORTHOPEDIC ASSOCIATION.

FIFTH ANNUAL SESSION, HELD AT WASHINGTON, D. C., SEPTEMBER 22, 23, 24, AND 25, 1891.

(Abstract of the proceedings.)

ORTHOPEDIC SURGERY AS A SPECIALTY.

Dr. A. B. Judson, of New York, in the president's address, said that orthopedic surgery is specially the domain of physical demonstration where subjective symptoms give place to objective signs, where treatment is chiefly mechanical, and where results are recorded in degrees of a circle and fractions of an inch. It exists and thrives as a specialty, because the general practitioner concurs with the public in committing patients who, from the nature of the case, generally recover with some deformity and disability to the care of experts.

CRURAL ASYMMETRY AND LATERAL CURVATURE.

Dr. H. L. Taylor, of New York, described two instances in which the leg was two inches and one and one-eighth inches short respectively. Both cases were in young women. The short limb was larger and stronger; the shortening was chiefly below the knee, and there was no lateral curvature.

Dr. A. Hoffa, of Wurzburg, Germany, described a specimen which proved that in one instance the shortness was due to union of the neck and shaft of the femur at an acute instead of an oblique angle.

Dr. F. Beely, of Berlin, illustrated with specimens of lateral curvature and ingenious models the changes which occur in the bodies of the vertebra preceding rotation, explaining how the para spinous sulcus is shallow and broad on the concave, and deep and narrow on the convex sides, a condition which is reversed in the lumbar region by the absence of ribs.

TREATMENT OF HIP DISEASE.

Dr. Phelps said that traction and fixation should be enforced to prevent destruction by intra-articular pressure. Ankylosis is the result, not of fixation, but of disease. The patient should be put to bed from three weeks to four months, and should then wear a lateral traction fixation splint, which was exhibited. Children under three years are placed in a plaster of Paris portable bed, which was also shown.

Dr. Wirt exhibited a new device for traction, in which the force of the lever is changed into rectilinear instead of circular motion without key, screw-driver, wrench, buckle, or strap.

Dr. R. H. Sayre, of New York, said the invention gave accurate and easy adjustment in the direction of traction, but in the direction of relaxation the control was defective.

Dr. Taylor practiced rest in bed with traction in the acute stage, to be followed by a splint which allows locomotion.

Dr. Sayre thought but few cases required lateral traction. When the inflammation had ceased, he applied passive motion If the pain and tenderness following last more than twenty-four hours, the passive motion had not been rightly used.

Dr. E. M. Moore, of Rochester, believed that a joint only moderately inflamed demands motion. He employed traction with a certain amount of motion.

CONGENITAL DISLOCATION OF THE HIP.

Dr. PHELPS exhibited apparatus for the treatment of this affection, and described his method and its results.

Dr. E. H. BRADFORD, of Boston, had modified the apparatus in previous use by adding an appliance with which the patient is allowed to walk about. The joint is thus protected as in convalescence from hip disease. These appliances he had made of aluminum for the sake of lightness.

Dr. C. C. FOSTER, of Cambridge, said the best recorded result had been obtained by Dr. Buckminster Brown, whose patient was treated by mechanical means in bed.

Dr. A. HOFFA had operated by deepening the acetabulum, which is practicable from the thickness of the pelvis at this point. At first he sewed a periosteal flap over the trochanter, but this is unnecessary. Two months ago he examined his first case, two years after the operation, and found a movable joint, freedom from the characteristic gait, and absence of lardosis.

Mr. HOWARD MARSH, of London, divided these cases into (1) those in which the bone slips about on the wall of the pelvis, and (2) those in which it is fixed. The majority belong to the second class, and in these operation is useless, but is more properly applicable to those cases of the first class in which the head is high up and movable. The anterior position is the most favorable, because lordosis, which depends on the backward displacement of the head of the femur, is absent.

MALIGNANT DISEASE AND POTTS' DISEASE.

Dr. JUDSON reported three cases in which Potts' disease and malignant disease of the vertebra had been confounded by himself and other observers. In one the diagnosis was made *ante mortem*. The patients were four and a half, thirty-five, and forty-two years respectively. The chief diagnostic points are: (1) Deformity present in Potts' disease, absent in malignant disease; (2) local disability; and (3) local pain; both absent in Potts', and present in malignant disease.

Dr. WILLARD had seen two cases in which his diagnosis was confirmed *post mortem*.

Dr. GIBNEY reported a case in a man of forty years, in which he and others had been baffled in diagnosis. There was sarcoma of the fifth and sixth cervical vertebræ.

Mr. Marsh related the case of a child which was extremely difficult to diagnosticate, and which proved to be malignant in character.

SYPHILITIC POTTS' DISEASE.

Dr. Ridlon said that in this form the onset is more rapid, the pain and disability greater, the kyphosis sharper in outline, and abscesses often appear before deformity. If recognized lesions of hereditary or tertiary taint are present, treatment should be by large doses of mercury and iodide of potassium.

POTTS' DISEASE IN THE OLD.

Mr. Marsh had observed instances of suppurative tuberculosis in the metacarpus, tarsus, testis, cervical glands, knee and hip, in eight patients between sixty-three and seventy-three years. But senile tuberculosis of the spine is most rare. He had seen two cases. The patients were sixty-four and sixty-five years respectively. The College of Surgeons of London possessed an osseous specimen of the action of senile tuberculosis of the upper cervical vertebra. In his "Studies of Old Case Books," Sir James Paget had recorded a case of Potts' disease in a gentleman of fifty-five attended with angular curvature.

Dr. Sayre recalled the case of a patient, *æt.* fifty-five, who recovered from Potts' disease with paraplegia and abscesses.

POTTS' DISEASE AND PREGNANCY.

Dr. T. H. Myers, of New York, had collected twenty-five cases of labor in fifteen patients recovered from Potts' disease. In no instance did caries recur. But of seven cases in which the disease developed during pregnancy, three died, and three were left paraplegic. Normal parturition often follows in cases of deformed pelves, whose measurement would indicate that it was impossible. These patients should be examined by the obstetrician early in gestation.

Dr. Taylor knew of many cured patients whose marriage had been followed by the birth of healthy children.

Dr. G. W. Ryan, of Cincinnati, thought it was a question of allowing the tuberculous to marry. He knew of married women, deformed by Potts' disease, who had borne and raised healthy children.

Dr. Lee said that one of his patients with a large lumbar kypho-

sis had borne twelve children who, with the mother, are all in good health. He thought Potts' disease, even in the lumbar region, rarely produced narrowing of the pelvis.

PARAPLEGIA IN POTTS' DISEASE.

Dr. BRACKETT said that relief from paraplegia may be confidently expected from continuous extension and fixation even in cases of eighteen months' standing. This should be continued for some time after recovery.

Dr. YOUNG reported two cases of complete recovery in which there had been absence of sensation, a feature aways of grave import.

Dr. SHAFFER referred to a case in which the autopsy showed that a portion of the eighth dorsal vertebra had nearly cut through the cord, leaving but a slender thread.

Dr. HOFFA said that in these cases the spine should be put absolutely at rest. He had collected thirteen operations within the vertebral canal. Two died at once, two recovered, and would, perhaps, have done so anyway. In the others there were immediate good results, but relapses soon occurred. The operation has no great future before it, and should be limited to those cases in which the processes alone are affected.

Mr. MARSH said that paralysis rarely depends on the pressure of an abscess, but (1) on softening of the core, (2) pressure of a displaced sequestrum, and (3) most common on pressure from exudation. He would only operate after thorough trial of rest.

Dr. WILLARD said that we could not absolutely diagnosticate the cause. When there are extensive inflammatory deposits about the arches, laminectomy may relieve the posterior pressure and allow expansion of the cord.

Dr. LEE said that in all cases of this form of paraplegia suspension would materially hasten recovery.

ABSCESSES IN POTTS' DISEASE.

Dr. TOWNSEND thought that, as a rule, these abscesses should not be opened. In some cases aspiration should be done, and in others the cavity should be opened and drained to prevent sepsis and danger to life. His views were based on the history of 380 patients, seventy-five of whom had abscesses.

Dr. VANCE advocated aspiration, repeated as often as fluid is

detected. In this way he cures three out of five cases. The depot is thus kept small, and the extent of subsequent operations, if necessary, is limited.

Mr. Marsh had rarely obtained a good result by the use of the aspirator. He said that in his observations it is best to open freely, evacuate thoroughly, and then apply pressure to assist in closing the cavity.

Dr. Willard would let dormant and caseating foci alone; liquefacting collections he would aspirate and inject with iodoform emulsion, and if true pus were present he would incise, wash out with sublimate solution, and avoid undue manipulation, which might cause fissures which would let the tuberculous poison into the system. He would then suture the incision and inject iodoform and boiled olive oil.

Dr. Shaffer would not say that incision was never advisable, but generally it is wrong to open one of these abscesses. A very large abscess cannot be washed out, and its disappearance may be confidentially expected, especially if efficient mechanical treatment is practicable.

Dr. Myers said that it was proven (1) that it is impossible to completely remove bacilli from the abscess cavity, and (2) that bacilli-infected wounds at times heal primarily. Infection is more imminent after incision, because the wound lays open channels of absorption.

WIRING THE VERTEBRAL PROCESSES.

Dr. Hadra suggested that the spinous processes at the seat of the disease be exposed, and then firmly wired together, to secure rest and prevent deformity. The operation, as he had performed it for fracture of the cervical spine, was extremely simple and effective.

Dr. Sayre thought the wires would not bear enough force to remove the weight from the vertebral bodies, and that outside protection would be necessary to prevent lateral and rotary disturbance.

Dr. Judson thought it was a question whether wiring was applicable through the long periods in which consolidation is delayed. Intolerance of the skin always prevents such pressure as we would like to make on the kyphos. The method proposed circumvents this difficulty.

Dr. Moore said it was a most simple and harmless procedure, and, notwithstanding the theoretical objections, he would accept the first favorable occasion to try it.

PROGNOSIS AND TREATMENT OF POTTS' DISEASE.

Dr. Ketch had learned from seventy-five cured cases that in length of treatment and degree of deformity the upper region of the spine is most favorable, and the middle least of all; that paraplegia more frequently accompanies disease in the upper than in the lower regions, and that cases of traumatic origin recover sooner than those of tubercular origin. Sudden deaths sometimes occur in cervical caries from interference with respiration.

Dr. B. Bartow, of Buffalo, said that the earliest important sign in the dorsal and lumbar regions is lateral curvature dependent on nervous tenderness. Apparatus should be constructed to oppose the rotation accompanying the lateral curvature, as well as the antero-posterior deformity. He used the plaster-of-Paris jacket applied to effect the above objects.

Dr. Foster said that extension in *bed* is the best method in the acute stage. Extension should be made by light weights, the cords leading over the head and foot of the bed, and attached to waist-belts, chest-belts, and head-straps.

Dr. Ryan said recumbency was the ideal treatment, but it is in many cases impracticable. He had found splint plaster jackets efficient after the acute stage.

Dr. Lee said that many years ago, when the plan had fallen into entire disuse, he was the first to adopt suspension from the practice of Dr. J. K. Mitchell. The apparatus was Le Vacher's head support and jury-mast, attached to a chair or go-cart, or to a door-way swing.

Dr. Sayre said that in the cervical and upper dorsal region a metal posterior splint, supported on the pelvis, should be used with a jury-mast, and in the lower dorsal and lumbar regions, a plaster-of-Paris jacket with a jury-mast. Recumbency should be practiced in the acute stage; children should not be placed in the wire cuirass.

Dr. Ketch had been disappointed with the plaster of Paris and jury-mast in the cervical and upper dorsal regions. He recommended the Taylor apparatus and chin-piece. In the lumbar region almost any supporting apparatus will secure a good result.

Dr. TAYLOR said that the antero-posterior lever secures rest and protection, and combats deformity. Old and neglected cases are especially amenable to treatment, just as ankylosis is later and rarer than is generally supposed. Abscesses and paraplegia do not forbid a favorable prognosis.

Dr. BRADFORD said that the plaster-of-Paris jacket was the readiest method, but had its disadvantages; that a steel brace gave better support, but demanded more skill and care; and that recumbency was the surest way to prevent deformity, but, as a rule, was impracticable for the long periods covered by the disease.

RHEUMATIC SPONDYLITIS.

Dr. RYAN said that this rare affection should not be confounded with rheumatoid arthritis of the spine. It is usually accompanied by rheumatic manifestations elsewhere. In the early stage the symptoms resemble those of tubercular spondylitis. Later the deformity is not angular, but resembles that of senile kyphosis. Treatment should be directed to the relief of pain by support, cautery, and medication. In the chronic form, when pain has lessened, mobility should be encouraged by passive motion.

Dr. HOADLEY deplored the confusion which is found in the nomenclature of these conditions, which produce such a variety of results. He thought both rheumatism and osteo-arthritis were microbic diseases. If ligamentous structures interfere with motion, passive motion was proper.

Dr. LEE was reminded of a case which was at first thought to be spinal myalgia, but which proved to be gouty disease of the cartilages, and infrequent affection. Apparatus afforded relief, but, of course, not cure.

Dr. RYAN said that gouty spondylitis is generally attended by manifestations in other parts of the body. He had failed to state that his patient had limited respiratory movements.

Dr. VANCE related a case in which there was, in addition to the spinal affection, complete immobilization of the thorax with chiefly diaphragmatic respiration.

Dr. BARTOW had seen a case in which relief was afforded by the spinal jacket.

Dr. GILLETTE reported a case which, at the first glance, resembled the deformity of Potts' disease, but which proved to be

rachitic in its etiology. Improvement followed a few days after suspension was begun.

SACRO-ILIAC DISEASE.

Dr. Lee said the sequence of events is as follows: (1) Injury of the synchondrosis; (2) subacute inflammation; (3) irritation of the nerves of the joint, transmitted to the nearest plexus; (4) resulting pain in the sciatic. The sciatica should be considered the result, not the cause, of all the trouble. In nine cases out of ten, neuralgia is the effect and not the cause of any trouble. As stooping in sacro-iliac disease is injurious, he had devised a handy instrument with which the patient can pick up an object from the floor while remaining erect.

BUFFALO MEDICAL AND SURGICAL ASSOCIATION.

Reported by W. S. RENNER, M. D., Secretary.

Stated Meeting, September 1st.

The President being absent, Dr. Bartlett occupied the chair.

Dr. A. E. Persons read a paper entitled, Disorders of Nutrition (continued).

DISCUSSION.

Dr. Van Peyma thought that most professional men were inclined to be lazy. We require more exercise to keep our digestive organs in repair.

Dr. A. L. Benedict does not consider washing out the stomach a curative agent; it is like washing the external surface of the body; it cleanses the stomach, the same as a bath washes the skin.

Dr. Coakley was glad to hear the reader emphasize "diet" in the treatment of stomach troubles, both in regard to its quality and quantity; much can often be attained by restricting the diet of a patient; many cases present peculiarities, some patients are better on an animal diet, some do best on a vegetable diet, some can take only fluids, others only solids. He thinks exercise is very important in these cases; it stimulates normal tissue changes; it should be taken in the open air; horseback riding is the best kind of exercise: it is exhilarating and the organs are well shaken up and are thereby made to secrete better. He agreed with Dr. Benedict in regard to the benefit arising from washing out the stomach.

Dr. PRYOR thinks that lavage in the treatment of the stomach is at present too much of a fad. He believes that *lavage* is useful in chronic catarrh where there is a large amount of mucus, which is preventing the food from coming in contact with the stomach walls and mixing with the gastric juice. He doubts the utility of electricity; it may give more motion to the muscular walls, but cannot reduce the size of a dilated stomach. He thought that Dr. Persons had confused lithemia with neurasthenia, and said that there was a great difference between these two conditions.

Dr. DUNHAM: Physical exercise, out-door work, and change of occupation often help these cases. He had had under his care a case of general tuberculosis with dilatation of the stomach, in which the condition of the stomach greatly improved within two weeks on five drops of tincture of the perchloride of iron with ten drops of the fluid extract of ergot, three times daily.

Dr. HAYD: Most of the disorders of nutrition are due to imperfect oxidation, thus filling the blood with excrementitious matter; consequently the method of overcoming these disorders is by taking out-door exercise. It naturally follows that we should be very careful what medicines we prescribe, for these conditions are usually found in people of sedentary habits, who become languid early in the day; these people smoke in the house: thus they paralyze the pneumogastric, and produce an atonic condition of the stomach.

When people say that lavage simply washes the stomach, they do not appreciate its therapeutic value; it tones up the muscular coat and increases the amount of hydrochloric acid, a fact which has been conclusively proven. It would be as foolish to apply medicines to the unwashed skin as it would be to give medicines in such cases without first washing out the stomach. The cases of dyspepsia which we meet every day do not usually require lavage, but exercise and care in taking food. He said that lithemia differed from neurasthenia, in that the patient with the first condition is extremely irritable.

Dr. GRANT said that reflexes often produce disturbances of the stomach. He related a case in which the patient had been troubled with hardness of hearing and cough; this patient vomited every morning. He removed a glass diamond from the child's ear, took it off cough-mixtures, etc. The patient recovered at once from all the symptoms. The symptoms in this case were due to reflex through the small branch of the pneumogastric, which goes to the ear.

Dr. Persons said that Dr. Pryor had misunderstood him in regard to lithemia and neurasthenia.

Selections.

MIDWIFERY AND DISEASES OF WOMEN.

ON THE CONTINUOUS IMPROVEMENTS IN METHOD IN CESARIAN SECTION.

Fraenkel (Ernst) — *Deutsche med. Wochenschrift*, Nos. 33 and 34, gives a concise summary of the gradual evolution of technique, from the crude old operation to the perfected methods of the latest scheme. He insists also upon the simplification necessary in the operative details, in order to place the procedure within the working area of the general practitioner; and puts it upon the level of tracheotomy in croup, and herniotomy in strangulated gut — accomplishments which it is within the power of the majority to possess.

Up to the introduction of Porro's operation, a decade back, the mortality of the old method of Cesarian section was about ninety per cent. A notable epoch was made by Porro's plan, the success following which was much greater, whilst the great objection consisted in the extensive mutilation necessary. Feeling the firmer ground reached by Porro, Sänger published a few years afterwards the details of a well-considered plan, by which the success of Porro should be maintained, whilst the objectionable mutilation should be obviated. Sänger's *Restitutio in Integrum*, somewhat modified, is the operation of the present day, and Fraenkel claims it as an advance as great as that of Langenbeck's subperiosteal resections over the old method of dismemberment.

Fraenkel points out that Sänger's plan differs in two main features from the old operation, namely: in the asepsis to be maintained, and in the plan of suturing. To this latter the author attached the greatest possible importance; as, in his view, the success of the operation depended on the prevention of sanguineous or lochial discharge from entering the serous cavity, and in the union of the uterine wound throughout by first intention. The plan of suturing and the material for suturing were of equal importance. The former Sänger gave under three heads: a muscular suture series, which was sufficiently numerous and sufficiently strong to practically seal the uterine wound from leakage; the perforation

of these sutures on the endometrial side, so as to miss the decidual tissue, thus avoiding later wound infection ; and finally, the closing of the serous visceral incision by a special row of sutures, any redundant serous membrane being cut away, and each serous edge infolded. The material used was silver wire.

Fraenkel shows at some length how and why the use of silver wire was gradually abandoned, how catgut was extensively tried, and finally how and why silk has been installed as the sole material for suturing. He records a case in which peritonitis spoilt an otherwise promising operation, it resulting from gaping in one or two spots of the uterine wound, where catgut had been used. Silk, also, is a stitch material within the reach of all, requiring no technical preparation for use. With the use of silk as suture, he shows further how it has not been found necessary to avoid puncturing the decidual membrane in suture introduction ; that it is not necessary to use a special row of sutures for the divided peritoneum, but that strong silk sutures, penetrating the serosa, muscle, and decidual membrane alike, may be used, and knotted independently on the serous aspect of the uterus.

A detailed account of a successful operation is given. The vagina was well cleansed with a three per cent. carbolic lotion. A median long abdominal incision was made, commencing four fingers' breadth over the umbilicus. The uterus was raised up, an elastic ligature placed loosely around the lower segment, and a twelve cm. long incision made into the uterine wall. This struck the placental site, the presenting part of which was detached, and the fetus rapidly delivered. The elastic ligature was now made tight, a sponge wrung out of sterilized salt solution placed in the uterine cavity, and the suturing of the uterine incision commenced. Sixteen strong silk sutures were inserted, perforating the peritoneum about one cm. from the wound edge and passing through serosa, muscle, and decidua successively. The sponge was removed, the sutures tied and knotted on the peritoneal side, and the last of a series of four hypodermic injections of ergotin, which had been given at short intervals during the suturing, was inserted. The elastic ligature was now removed, the uterus had well contracted but still some oozing occurred in three spots in the line of incision. An additional suture was inserted at each bleeding spot, and found sufficient to check further flow. The remainder of the operation was concluded in the usual manner.

[The late Carl Braun advocated and practised in the Vienna

Universitäts-Klinik, the plan of suturing the slit in the parietal peritoneum so as to include the slit in the visceral peritoneum also. In this way adhesion of the serous surfaces at the lines of incision occurred, the general peritoneal sac was cut off, and exit for any wound secretions took place through the lower angle of the parietal incision purposely stuffed with iodoform wick.]

Fraenkel concludes by discussing the principal elements of the operation at some length. The general scheme is to simplify the details as much as possible, so as to bring the operation easily within the skill and the resources of the general practitioner. The necessity for strict asepsis of hands and instruments, and dressings, and the "dry treatment" of the peritoneum is insisted on.

Three assistants are necessary: one to assist the operator, another to be responsible for the instruments, and the third to anesthetise. The preliminary hypodermic of atropine-morphine often given, is, in these cases, to be omitted, the former alkaloid interfering with the prompt contraction of the uterus, so essential to success. To ensure this latter, several hypodermics of ergotin are given, beginning directly after the extraction of the fetus. The lifting up of the uterus through the abdominal incision is desirable, partly to allow the easy passing of the elastic ligature, and partly to give space for the insertion of three or four provisional sutures in the parietes, to prevent uterine fluids from entering the serous cavity. The quicker the uterine suturing is conducted, the shorter is the time for full constriction by the elastic ligature, and the less the risk of uterine atony following its removal.

Not every case is suitable for the conservative operation. Where a marked pyrexia already exists, or the decidual membrane shows distinct signs of decomposition or disintegration, or if the operative interference has been unduly deferred, or efforts at delivery made by persons of indifferent cleanliness, then the propriety of the Porro as diminishing the risk of peritonitis is to be considered. In doubtful cases, Fraenkel advises Porro's operation as safer than the Kaiserschnitt. C. H. Burford.

—*Medical Chronicle.*

SUBCUTANEOUS INJECTIONS OF IRON.

Dr. Rosenthal has made an interesting study of the action of subcutaneous injections of iron in nervous affections. By personal experiment he ascertained that when a preparation of iron was administered subcutaneously, it was absorbed thirty to forty min-

utes after injection, and could be detected in the urine. From the basis of a long series of investigations, the author recommends two iron preparations for hypodermic injection. One is the so-called ferrum peptonatum, obtained by the decomposition of ferric chloride solution with solution of pepsin, as a brownish-yellow powder, readily soluble in water. It is applied in aqueous solution (1 to 10), one syringeful being given every second day. The second suitable preparation is ferrum oleatum, diluted to one to twenty by olive oil, and used similarly. Of the two, the former is preferable, on account of its greater solubility and stability. The subcutaneous iron treatment is recommended by Rosenthal in delicate neurasthenic persons, and in the asthenic dyspepsia, so often associated with anemia, in which small doses of iron may produce considerable digestive disturbance. Unpleasant by-effects did not appear.—*Provincial Medical Journal*, September 1, 1891.—*Therapeutic Gazette.*

Therapeutic Notes.

METRIC FORMULÆ.

Adopted from the prescriptions of various authorities to this system by A. L. Benedict, M. D., Buffalo, N. Y.

R.—Iodi	1.00
Potassii iodidi	10.00
Glycerini	25.00
Aquam ad	100.00

In spray or on applicator to nose, pharynx, etc.

R.—Plumbi acetatis	1.00
Tr. opii	10.00
Aquam ad	100.00

Lead and opium wash for bruises, cellulitis, etc.

R.—Sodii bicarb	2.00
Sodii (quadræ) boratis	2.00
Potassii chloratis	5.00
Ac. carbolici	.50
Glycerini	25.00
Aquam ad	100.00

Astringent, Dobell's solution.

R.—Felis bovis inspiss. 10.00
Ext. conii 3.00
Saponis duri 5.00
Olei olivæ q. s. ad 50.00

To absorb hypertrophies.

R.—Tr. belladonnæ 10.00
Lin. chloroformi 30.00
Lin. ammoniæ 30.00
Lin. saponis ad 100.00

Liniment to combine counter-irritation with relief of pain.

R.—Ichthyol 30.00
Ung. hydrargyri 30.00
Ung. belladonnæ ad 100.00

First stage of tuberculosis of joints, epididimitis, etc.

R.—Ac. salicylici 3.00
Ac. boracici 20.00
Aquam ad 1000.00

Thiersch solution, antiseptic for peritoneal cavity, eye, etc., where there is danger of absorption, or of irritant local action of mercury.

R.—Ung. hydrargyri nitratis 2.50
Petrolati 25.00

Itching piles, locally.

R.—Ung. gallæ .....
Ung. hydrarg. ammon. aa 10.00

Bleeding piles, locally.

R.—Potassii chloratis 1.00
Tr. opii 1.50
Aq. amyli 15.00

Injection, to be retained for local action on hemorrhoids.

R.—Ac. borici 1.50
Glycerini 15.00
Aquam ad 100.00

Use as spray in catarrhal pneumonia, dry bronchitis, etc., to render secretion less viscid.

BUFFALO MEDICAL AND SURGICAL JOURNAL

A MONTHLY REVIEW OF MEDICINE AND SURGERY.

EDITORS:

THOMAS LOTHROP, M. D. - - WM. WARREN POTTER, M. D.

All communications, whether of a literary or business character, should be addressed to the managing editor: 284 FRANKLIN STREET, BUFFALO, N. Y.

VOL. XXXI. NOVEMBER, 1891. No. 4.

THE PAN-AMERICAN MEDICAL CONGRESS.

OUR readers are undoubtedly familiar with the fact, that at the last meeting of the American Medical Association, held in Washington, May, 1891, a committee, consisting of one member from each State and Territory, was appointed to organize a medical congress, which should be composed of delegates and members from the several countries comprising the Western Hemisphere. This committee met in the city of St. Louis, October 14, 15, and 16, 1891, and perfected the organization of the proposed medical congress.

Dr. Chas. A. L. Reed, Chairman, called the committee to order at four o'clock on the 14th, and it continued its work during the 15th and 16th, until the organization was finally perfected. Washington was chosen as the place of meeting, and the date fixed upon was the first Tuesday of October, 1893.

Dr. William Pepper, of Philadelphia, was elected President, and Dr. Chas. A. L. Reed, of Cincinnati, was chosen for the important office of Secretary-General. To Dr. Reed is due the conception and inauguration of the systematic scheme and extensive correspondence with professional men, not only in the United States and Canada, but in the South American Republics, which has finally resulted in organizing the first Pan-American Medical Congress ever proposed or held. It was a graceful act on the part of the committee to select Dr. Reed for the important post of Secretary-General, and it may be affirmed that no man in this country is more familiar with the duties pertaining to that office than the accomplished Cincinnatian who has been selected to fill it.

There are so many details connected with the organization of such a congress, that it is highly important that a man of great

executive capacity should be at the helm. Dr. Pepper's talent in the direction named is well known, and he is a conspicuous American physician of great and versatile resource. With Dr. Pepper and Dr. Reed pulling together, like a double team in well and easily fitting harness, as they no doubt will, it may be assumed that the first Pan-American Medical Congress is already an assured success. The remainder of the organization, such as vice-presidents and officers of sections, will be duly announced, and, no doubt, the journals will soon give the full list. Let the profession and the government of the United States yield cordial support to a grand enterprise so auspiciously inaugurated.

THE MISSISSIPPI VALLEY MEDICAL ASSOCIATION.

The seventeenth annual meeting of this famous medical body was held in St. Louis, October 14, 15, and 16, 1891. Though this Association has been noted for large and enthusiastic meetings, the writer was told that the late one was the largest ever held, and that the enthusiasm was never greater. The registration list showed about three hundred names recorded, and this alone indicates the activity, life and prosperity of the Society. There are so many medical organizations in this country, that it is a wonder how they are all kept alive. It is a marvel to find men, whose time is money, and whose capital consists of brains and time, willing to travel across the continent, and from gulf to lakes, for the purpose of mingling with their professional brethren, and exchanging thoughts with each other on important medical questions. In the Southwest, particularly, there are several subordinate medical associations, made up of a union of two or more States, or of portions of States, in which latter case they are called District Medical Societies, so that the number is almost without limit; nevertheless the enterprising physicians of the Mississippi Valley, appreciating the importance of frequently gathering together and touching elbows on questions that are agitating the medical world —questions of improved sanitation, of clean surgery and advanced midwifery, questions which relate to the prolongation of life, to the alleviation of human suffering, questions which make the race better, stronger, and purer—the physicians, we repeat, of this great and fertile region are not slow to grasp any and every opportunity to advance the science and art of medicine, to which they all seem

to be so devotedly attached. The Association was particularly fortunate in the selection of its amiable and accomplished President, and Dr. C. H. Hughes, of St. Louis, will long be remembered for the strength and popularity of his administration of the affairs of this Association on this occasion. Another fortunate circumstance, that contributed not a little to the success of the meeting, was the selection of Dr. I. N. Love as Chairman of the Committee of Arrangements. It is easy to be seen that Dr. Love is the most popular physician of St. Louis, and this may be said without disparagement to any other. For a man of his years to have acquired his position, both professionally and socially, to be able to direct large affairs on such a large scale, and to actually rise head and shoulders above all others in such an important medical enterprise, is alone evidence of his magnetism, his amiability, his talent, and his goodness.

The receptions of Dr. Hughes, Dr. Bond, and Dr. Love were brilliant social events, marked for the beauty, fashion and wealth that gathered in their salons, and contributed not a little to strengthen the attachments which grow out of such a meeting. The banquet, on Thursday, at the Lindell Hotel, was one of the most brilliant medical feasts that has ever been given in this country. It was presided over by the talented and handsome Governor of Missouri, the Hon. David R. Francis, and Dr. I. N. Love acted as toastmaster, which is a sufficient guarantee of the brilliancy of the intellectual part of the feast. A number of toasts were responded to, and the guests lingered around the table until four o'clock A. M. Taken all in all, judged from any point of view, the seventeenth annual meeting of the Mississippi Valley Medical Association must be regarded as a pronounced success.

Dr. Chas. A. L. Reed, of Cincinnati, was elected President for the ensuing year, and the next meeting will be held in Cincinnati, in October, 1892.

STATE Board of Examiners—"Of what college are you a graduate?"

Candidate—"Of none. I thank God my intellect was never warped by college training."

Board—"Then you thank God for your ignorance?"

Candidate—"You can put it that way if you choose."

Board—"Yes, and we find you have a great deal to be thankful for."—*Kansas Medical Journal.*

Personal.

Dr. E. Arnold Praeger, of Nanaimo, B. C., read the address on Surgery at the recent meeting of the Canadian Medical Association. It was an able exposition of the present position of spinal surgery. Dr. Praeger is one of the most progressive and able of Canadian surgeons. He attended the annual meeting of the American Association of Obstetricians and Gynecologists in New York, and then went on to the Washington Congress of American Physicians and Surgeons. We trust that this genial citizen of British Columbia will visit the United States "early and often."

Dr. and Mrs. Henry Gibbons, Jr., of San Francisco, have started East on an eight months' vacation, and will soon sail for Europe. Most of this time will be spent in medical study and observation, and London will be mainly their residence while absent, where Dr. Gibbons, himself an experienced teacher, will have ample opportunity to compare and contrast English and American methods, especially with reference to obstetrics, which department he teaches in Cooper Medical College.

Dr. M. B. Ward, of Topeka, Kansas, accompanied by Mrs. Ward, visited the East, and read a paper before the American Association of Obstetricians and Gynecologists, at the New York Academy of Medicine, in September. Dr. Ward is one of the foremost physicians in the West, and his paper, entitled Removal of the Uterine Appendages, with Results, was full of interest, and was received and discussed with great enthusiasm.

Dr. John A. Ouchterlony, of Louisville, has presented to the Catholic University at Washington, D. C., a large and valuable archeological collection, illustrating the prehistoric antiquities of the Mississippi valley.—*Kansas Medical Journal.*

Dr. Edward Clark, of Buffalo, attended the annual meeting of the American Public Health Association, at Kansas City, October 19-23, 1891, where he read a paper on The Collection and Transportation of Garbage in Cities.

Obituary.

Brigadier-General Joseph B. Brown, Surgeon U. S. Army (retired), died Oct. 21, 1891, at his home in Albion, N. Y. Dr. Brown rendered conspicuous service in the late Civil War, and was Medical Director of Keyes's (the fourth), and Franklin's (the sixth) Army Corps during McClellan's peninsular campaign. The writer was Assistant Surgeon of the Forty-ninth Regiment New York Volunteers (General Bidwell's) during this period, and it was Dr. Brown who brought him an order from General Franklin, during the battle of Savage's Station, June 29, 1862, to remain with the wounded that were to be left behind to fall into the enemy's hands. Dr. Brown received his Brevet Brigadier-General for meritorious service during an epidemic of yellow fever several years ago.

Journalistic Notes.

Journal of Balneology and Dietary.—We take pleasure in advising our readers that A. N. Bell, A. M., M. D., of Brooklyn, Frank Woodbury, A. M., M. D., of Philadelphia, and Geo. H. Rohé, M. D., of Catonsville, Md., will in future conjointly direct the editorial department of this *Journal*. The well-earned reputation of these gentlemen is sufficient assurance that they will discuss with authority the subjects coming within the scope of this publication. Drs. Bell and Rohé have long been prominently identified with the progress of sanitary science in this country, and as authors of important works on climatology, balneology, and hygiene. Dr. Woodbury is too well-known as an accomplished medical editor and writer on dietetic subjects to require further introduction. Extensive arrangements have been made for contributors among the most noted experts in this country and abroad, who are regarded as authorities upon the special subject to which this magazine is devoted. Address, P. O. Box 1670, New York.

The October number of the *Alienist and Neurologist* contained one of the most complete and practical papers on the subject of Traumatic Neuroses and Spinal Concussion ever written; the best paper extant on The Insanity of Torquato Tasso; an Exhaustive

Study of Criminals and their Cranial Development; The Weight of the Brains of the Feeble-Minded; A Study of the Heredity of Inebriety. The respective writers are Guiseppe Seppilli, Italy; W. W. Ireland, Scotland; G. Frank Lydston, Chicago; A. W. Wilmarth, Pennsylvania; and T. L. Wright, Ohio. It also contained the usual selections, editorials, hospital notes, reviews, etc. The editor is C. H. Hughes, M. D., 500 N. Jefferson avenue, St. Louis. Subscription, $5.00 per annum; single copy, $1.50.

The Daily Medical News is a new venture in medical periodical literature. It is edited and published in Philadelphia by Dr. Joseph F. Edwards. The third number, dated October 13, 1891, has been sent us, and we commend the enterprise that puts forth such a daring scheme as the publishing of a daily medical newspaper.

"Do you rectify mistakes here?" asked a gentleman, as he stepped into a drug store. "Yes, sir, we do, if the patient is still alive," replied the urbane clerk.—*Ex.*

Medical College Notes.

The College of Physicians and Surgeons, of Chicago, Ill., announces a non-resident course of instruction in the following terms:

1. Non-residents may matriculate to take the first year's course in the same manner and under the same conditions as if they proposed to take a resident course. (*V.* Catalogue).

2. Non-resident students will be required to select a preceptor satisfactory to the secretary, and one who is willing to coöperate with the faculty in conducting the year's work, and give his certificate for the same at the end of the year.

3. Non-resident students must do the prescribed work and make satisfactory weekly reports of progress in the manner provided by the faculty.

4. The course covers thirty weeks, and not more than five weekly reports may prove unsatisfactory without debarring the student from the credit of the course.

5. When a student can furnish evidence of having already

taken the work in the prescribed non-resident course, he will be assigned an equivalent from a special course.

6. Students who have taken the non-resident course in a satisfactory manner, and have shown by the weekly examinations that they have done the work thoroughly and intelligently, will receive certificates from the secretary, which, with the certificate of their preceptor, will be taken at this college in lieu of one year's study on a four years' course. Address,

DR. BAYARD HOLMES, *Secretary.*

240 Washington Ave., Chicago, Ill.

Society Meetings.

THE SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION will hold its fourth annual meeting in Richmond, Va., November 10, 11, and 12, 1891, under the presidency of Dr. Lewis S. McMurtry, of Louisville, Ky. This association is doing a most useful work for the profession in the South, in whose interest it was mainly organized. There is no grander medical society anywhere than this, and we bespeak for it a continued and lasting existence. The titles of the papers to be read in the forthcoming meeting indicate that it will be one of especial excellence. Members of the profession everywhere are cordially invited to attend. Dr. W. E. B. Davis, of Birmingham, Ala., is the secretary, and Dr. Hunter McGuire, of Richmond, is chairman of the committee of arrangements. These, together with the president, constitute a triad of scientific workers of which any society may well be proud.

Book Reviews.

TRANSACTIONS OF THE MEDICAL SOCIETY OF THE STATE NEW YORK FOR THE YEAR 1891. Edited by FREDERIC C. CURTIS, M. D., Secretary of the Society. Octavo, pp. viii.—560. Published by the Society. 1891.

This volume of 560 octavo pages presents the work of this Society at its last meeting, and is most admirably edited by its accomplished secretary. The contents includes fifty-four scientific communications, besides reports of committees, obituary notices, lists of members and delegates, as well as members of the county

medical societies, and, altogether, it is a most useful book, whether looked upon as a work of reference, or whether judged from its scientific excellence. There are 4,342 members of the county societies, and 919 members of incorporated voluntary medical societies, in affiliation with the State society. It has a representation of 147 delegates, and a permanent membership which aggregates 265, besides honorary and non-resident members.

In the volume before us there is so much of scientific interest, that it is difficult to particularize, but two subjects are of especial value, and ought to be read by every physician in the State. We refer to the discussions on Tuberculosis and Appendicitis. The former includes titles by Drs. H. R. Hopkins, Heneage Gibbs, John O. Roe, Samuel B. Ward, and E. L. Shurley, and these are followed by papers on the use of Koch's lymph, by Drs. Jacobi and Heineman. The subject of appendicitis is treated by Drs. Herman Mynter, Chas. McBurney, W. W. Keen, Lewis A. Stimpson, Geo. Ryerson Fowler, Robert F. Weir, and A. Vander Veer.

Another discussion that deserves notice is that on Pelvic Inflammation in Women, which was participated in by Drs. Andrew F. Currier, A. J. C. Skene, and Lewis S. McMurtry. Other papers of importance were presented by Dr. Jas. F. W. Ross, on An Inquiry into our Present Knowledge in the Progress of Myomatous Tumors; one on the Treatment of Gall-stones, by Dr. Wm. Wotkins Seymour; and one on Operative Procedures in Acute General Sup purative Peritonitis, by Dr. W. E. B. Davis, of Birmingham, Ala. The scientific value of this volume has not been excelled by any society proceedings with which we are familiar. Those members of the profession throughout the State who have not already obtained it, should not be slow to purchase. It is doubtful whether as much valuable literature can be obtained anywhere else for the price, namely, $1.50.

INDEX-CATALOGUE OF THE LIBRARY OF THE SURGEON-GENERAL'S OFFICE, UNITED STATES ARMY. Authors and Subjects. Vol. XII. REGER-SHUTTLEWORTH. Quarto, pp. 1004. Compiled by JOHN S. BILLINGS, Surgeon United States Army. Washington: Government Printing Office. 1891.

This twelfth volume of the Index-Catalogue of the Surgeon-General's Office brings the work down to and including Reger-Shuttleworth. It contains 20,215 author's titles, representing 8,022 volumes and 18,090 pamphlets. It also includes 6,603 subject-titles of separate books and pamphlets, and 18,956 titles of articles

in periodicals. This gives a total, up to date, in the twelve volumes of 137,578 author-titles, representing 66,855 volumes and 120,000 pamphlets; also 128,284 subject-titles of separate books and pamphlets, 393,808 titles of articles and periodicals, and 4,335 portraits. This easily makes it the most complete index-catalogue of any library in the world—and the end is not yet.

It is a wonderful collection of medical literature, and when we reflect that it is open to the use of the medical profession of America, we can but feel that each one of us has a special interest in this library. It is expected to complete the catalogue within the next three years, but, of course, much material has accumulated since this work was begun, hence the necessity for the issuance of additional volumes. It is further expected that this work will be continued as fast as the literature accumulates, so that practically the Index will become an annual. The medical profession of America owes the compiler a debt of gratitude for his great labor.

A TEXT-BOOK OF BACTERIOLOGY. By CARL FRAENKEL, M. D., Professor of Hygiene, University of Konigsberg. Third edition: translated and edited by J. H. LINDSLEY, M. D., Professor of Pathology and Bacteriology, Medical Department of the University of Vermont; Demonstrator of Pathology and Bacteriology, New York Post-Graduate Medical School and Hospital, etc., etc. Octavo, 380 pages. Extra muslin, $3.75. New York: William Wood & Company.

The scope of this work on Bacteriology is broader than the one next reviewed, in that it is intended for beginners in bacteriology. The names of its author and translator are sufficient to stamp it as authoritative, and, in a new science like bacteriology, no information is so good as that which comes from the fountain-head. To all American students who have worked under Professor Fraenkel, this translation will be joyfully welcomed.

The first few chapters are devoted to the methods of investigation, and so thoroughly is each step explained, that the student need have but patience and the materials to follow out the instructions. The development of the microscope to keep pace with the requirements of this subject, the points of superiority of the various stains and their formulæ, the methods of breeding, preparation of the different cultures, sterilization, etc., etc., are all carefully and minutely described.

Chapter IV. is devoted to questions pertaining to the bacteria themselves—their powers of resistance, mode of transmission,

Metchnikoff's phagocytic theory, of which the author seems to be somewhat in doubt, Koch's rules for the determination of pathogenic bacteria, theories of immunity, etc.

Chapter V. treats of the non-pathogenic bacteria, and Chapter VI. of the pathogenic, or those bacteria which, by their vital action, produce excretions injurious to the bodies of men and animals. In the discussion of these forms, the author has omitted those theories not founded on fact or observation, and treats only of things which bear strict criticism. Some thirty-two varieties of bacteria are treated under the head of pathogenic, and we have but one criticism to offer, namely, that no plates or illustrations are found in the whole treatise. We deem this a serious mistake, for, in all text-books, the illustrations—if they be accurate—convey more information than the text. The mold and yeast fungi are considered rather too briefly in the appendix. One thing is apparent in the perusal of the work, and that is the vast debt which bacteriology owes to its founder—Koch.

The typographical work is by William Wood & Company, and in succeeding editions we hope they will insist upon having well-executed plates, such as one would expect from the author.

W. C. K.

Surgical Bacteriology. By N. Senn, M. D., Ph. D., Professor of Surgery in Rush Medical College, Chicago, and in the Chicago Polyclinic; Attending Surgeon to the Milwaukee Hospital; Consulting Surgeon to the Milwaukee County Hospital, and to the Milwaukee County Insane Asylum; Honorary Fellow College of Physicians of Philadelphia; Permanent Member of the German Congress of Surgeons; Corresponding Member Harveian Society, London; Honorary Member of La Academia de la Medicina de Mexico, etc. Second edition, thoroughly revised. Philadelphia: Lea Brothers & Co. 1891.

Whether the speedy exhaustion of the first edition of this work was due to the popularity of its author, or to the increasing interest in bacteriology, it is a pleasure to know that the subject has taken deep root among the medical men of America. Although not pursuing this line of work as actively as our foreign brethren, yet we are ready and willing to grasp and digest all that is prepared for us by those more favorably situated. Among the American bacteriologists, Professor Senn stands near the head, and his writings, therefore, possess weight and carry conviction. The volume before us is, strictly speaking, an exhaustive compend of the work done in recent years, and teems with extracts gathered from the

writings of the ablest workers on the various subjects connected with bacteriology. Opinions and experiments at variance with each other are both presented, without any effort to harmonize them, except when the observations of the author, based upon original research, may tend to carry conviction to the one side or to the other. Even to those not especially interested in the study of microörganisms, the discussion in such chapters as The Hereditary Transmission of Microbic Diseases; Do Pathogenic Microörganisms Exist in the Healthy Body? Sources of Infection, etc., etc., must be of the greatest importance. Although more especially intended for the surgeon-pathologist, yet the general practitioner will find a full and free discussion of nearly all the microbic diseases with which he comes in contact. It is surprising the amount of literature mastered by Dr. Senn in the preparation of this work— the authors running into the hundreds. Twelve plates, illustrative of the various bacilli, embellish the book.

W. C. K.

TEXT-BOOK OF MEDICAL JURISPRUDENCE AND TOXICOLOGY. By JOHN J. REESE, M. D., Professor of Medical Jurisprudence and Toxicology in the University of Pennsylvania; late President of the Medical Jurisprudence Society of Philadelphia; Honorary Member of the New York Academy of Anthropology; Corresponding Member of the New York Medico-legal Society, etc. Third edition, revised and enlarged. Small octavo, pp. xvi.—666. Philadelphia: P. Blakiston, Son & Co. 1891.

After a careful perusal of its pages, we lay this volume aside with the profound impression that it should be in the hands of every medical student, physician and lawyer.

The demand for a third edition within two years is a very flattering testimonial of the high esteem in which this work is held by the profession at large.

While the book on the whole is excellent, and we do not hesitate for a single instant to recommend it to the profession, still there are some things in which we do not agree with the author. For example, we do not approve of the administration of bicarbonate of potassium or sodium in cases of mineral acid poisoning. We consider this method of treatment dangerous and liable to lead to rupture of the stomach walls.

In addition to what the author has to say on the treatment of cases of mercurial poisoning, we would add "continue the administration of albumin (white of egg) for one week after the acute symptoms have disappeared."

Under the heading "Poisoning by Opium — Treatment," the author makes no mention of "forced respiration," a method of treatment which has proven efficient in a number of apparently hopeless cases of opium poisoning.

We make these remarks not for the purpose of depreciating in any way the value of this book, but for the purpose of pointing out what we consider are defects in an otherwise excellent volume.

The task of the reviewer is certainly not an enviable one, and we appreciate most fully the difficulties which he has to meet. But we also feel that a review which has been written after a careful perusal of a book, and in which the good points are mentioned and the bad ones called attention to, is of far greater value to the publisher, author, and public in general than one written from the preface alone. J. A. M.

TRANSACTIONS OF THE SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION. Vol. III. Third Session, held at Atlanta, Ga., November 11, 12, and 13, 1890. Edited by Wm. E. B. DAVIS, M. D., Secretary, and printed by WILLIAM J. DORNAN. Octavo., pp. xli. —444. Philadelphia: Published by the Association. 1891.

The volume before us records the work done by this wonderful Association during its third annual session, held at Atlanta, November 11, 12, and 13, 1890. The organization numbers now about 100 members, and its transactions take rank in scientific value with those of the foremost special societies of the world. It is most superbly edited by the accomplished Secretary of the Association, Dr. W. E. B. Davis, of Birmingham, Ala., and it is printed in Dornan's best style. This is giving the Association great praise, but not more than it merits, for these two men, Davis to edit the volume and Dornan to print it, constitute a team that could not fail to make a good book. The discussions on the papers in this book are very strong, and increase the value of the volume very much. The Association did itself great honor in electing Dr. Lewis S. McMurtry, of Louisville, President for the present year, and he will preside at the coming annual meeting, to be held in Richmond, November 10, 11, and 12, 1891. It is needless to say that Dr. Davis was continued as Secretary, and that these two, President and Secretary, pulling together, will secure an attractive and valuable programme for the approaching meeting. We advise every surgeon and gynecologist, who can do so, to attend, and we further advise all who cannot attend the meeting to purchase the Transactions. They will feel amply repaid for the outlay.

MINOR SURGERY AND BANDAGING, including the Treatment of Fractures and Dislocations, Tracheotomy, Intubation of the Larynx, Ligations of Arteries, and Amputations. By HENRY R. WHARTON, M. D., Demonstrator of Surgery and Lecturer on Surgical Diseases of Children in the University of Pennsylvania, etc. In one very handsome 12mo volume of 491 pages, with 103 illustrations. Enameled cloth, $3.00. Philadelphia: Lea Brothers & Co. 1891.

The surgery of the present period, which may be properly called the new surgery,—the surgery of antisepsis, of simplicity, and of cleanliness,—is also a surgery of success and cure; but the very conditions which have advanced surgery to its present state of triumph, have also necessitated the re-writing of most of the treatises that were formerly accepted as guides, or else of the publication of entirely new works cast upon the modern lines of pathology and treatment. This is as clearly true of the subject of bandaging as of any subordinate branch on the department of general surgery. Dr. Wharton has furnished an admirable treatise on Minor Surgery and Bandaging, which also includes many of the lesser details that are not to be found in the more elaborate treatises that are called text-books. In our opinion, the present work should be adopted as a text-book in our colleges, for it contains more practical surgery within its limits and boundaries than any book of its kind we have ever seen. The illustrations are especially good, made from clear and correct drawings, or else have been reproduced from photographs. It is difficult to see how even a tyro could fail to understand the application, for instance, of the dressing for fracture of the upper humerus, after looking at the picture on page 322. Some of the cuts in this book are recognized as old friends, taken from Liston, Cooper, and Fergusson, but such are generally classic illustrations of given conditions, upon which no improvements could be made. One of the strongest sections of the book is that upon Sutures, which we commend for the clearness of the illustrations, as well as the text. Taken altogether, we are more than satisfied with this attempt to place before the profession an abridgement of general surgery, which shall be instructive and scientific, without, at the same time, being classed among those books that are prepared for the purpose of cramming a student for final examination. Minor surgery has become a legitimate subdivision of the general field, and such being the case, it is well to have the best literature possible. In the present case, no mistake has been made in placing the preparation of such a treatise in the hands of Wharton, who has proven himself up to his work.

The publishers have put the volume into an attractive and substantial dress.

Lectures on Tumors, from a Clinical Standpoint. By John B. Hamilton, M. D., LL. D., Professor of Principles of Surgery and Clinical Surgery, Rush Medical College, Chicago, and in the Chicago Polyclinic; formerly Supervising Surgeon-General U. S. Marine Hospital Service, etc., etc. For the use of students. *Physicians' Leisure Library.* Detroit: George S. Davis. 1891. Price, cloth, 50 cents; paper, 25 cents.

The author of this little work is an experienced teacher and a thorough student. He is also one of the foremost surgeons of the land, and whatever he says will command attention because of this fact. It is important for a practitioner in the study of tumors, to have a guide that will enable him to follow out intelligently their clinical history. Very few are able to classify them properly in their own mind, hence find difficulty in interpreting their clinical manifestations correctly. Dr. Hamilton is not satisfied with the nomenclature and classification which he is obliged to follow, but still claims that is better than none, and must be adhered to until the next revision by the constituted authorities. The present one was adopted by the Royal College of Surgeons of London, and the American Medical Association, jointly, in 1880. Another revision will soon be ready for utilization, and we presume future editions of this book will conform to the modifications proposed. There are some errors in typography, which also then may be corrected, but taken altogether it is one of the clearest expositions on this difficult subject that has yet appeared, and its price is such as to bring it within the means of every physician. There need be no excuse hereafter for want of knowledge on this subject.

Heredity, Health and Personal Beauty. By John V. Shoemaker, A. M., M. D., Professor of Materia Medica and Pharmacology, Therapeutics and Clinical Medicine, and Clinical Professor of Diseases of the Skin in the Medico-Chirurgical College of Philadelphia; Physician to the Medico-Chirurgical Hospital, etc. Octavo, pp. xv. —122. Philadelphia and London: F. A. Davis. 1890. Price, cloth, $2.50; half morocco, $3.50, net.

This is a work intended in part for the profession and in part for the laity; that is to say,—it is written with a view to correct some popular errors regarding the rule of evolution and the law governing inheritance, and also to give the non-professional reader instruction in regard to the hygienic care of the person. While we recog-

nize the propriety of addressing both audiences on the subjects that Dr. Shoemaker has discussed, yet we are of the opinion that it would be better to do so in separate treatises. We shall simply comment on this one with reference to the hygienic care of the person. Here readers will find how to make themselves not only healthful, but handsome in the best sense of the word. If a woman would make herself beautiful, she must first make herself healthful, because no artificial means will restore beauty or healthful color to faded cheeks, or obliterate the wrinkles that dissipation or age has produced. The chapter on Food in its relation to Health, Beauty, and Pleasure, is one that every person may read with benefit; so also in regard to that upon Clothing in its relation to Health; and Ventilation in its relation to Health, as well as the several chapters on the care of the organs of special senses. Another section of the book that is of extreme value is that comprising two chapters, relating to the Bath. There is no greater contributor to health than a properly taken bath at proper intervals. The truth is, that very few attend to bathing as a hygienic measure, and sometimes it is sadly neglected as a cleanly one. We have neither the time nor space to give this book a critical review, but commend it to the consideration of the reading public as one that will afford considerable pleasure as well as a reasonable share of benefit. The publisher has dressed the book in a neat and tasteful garb, and has printed it on excellent paper, with clear type.

THE MOTHER'S HAND-BOOK. A Practical Treatise on the Management of Children in Health and Disease. With an Appendix containing Articles on Diseases and Accidents that may suddenly happen to Grown Persons. By LEVIN J. WOOLLEN, M. D. Richmond, Va.: Everett Waddy Co. 1891.

This volume is a handsomely attired octavo on an important subject, and, no doubt, will do much good by disseminating useful information among non-professional readers, especially mothers, for whom it is more particularly intended. The title would indicate that it is a practical treatise on the management of children in health and disease, but we are of the opinion that it is not so much a practical treatise as it is a guide to the home management of children, where something must be done before the doctor comes. The fact is, no book can inform any mother how to manage her children independently of the family physician, and the further fact is, that no doctor has a right to prepare a book expecting to accomplish this impossible feat.

In the work before us will be found much valuable information written in a popular style, and certainly it may properly form part of a mother's library, but it is to be regarded more as a guide to hygienic care rather than to medical treatment. An appendix is added, which contains articles on Diseases and Accidents which may suddenly happen to grown persons. Why such an addendum has been made to the Mother's Hand-book does not appear; but here it is, and so we conclude there must be a necessity for such commingling of heterogeneous subjects. The printing of this book has been handsomely done by the Everett Waddy Co., of Richmond. Surely, if Richmond can do such beautiful work, it is an indication that she is rapidly outstripping some of her Northern sisters of greater pretension but less action.

An Elementary Hand-Book on Potable Water. By Floyd Davis, M. Sc., Ph. D.; Professor of General and Applied Chemistry in Drake University; Chemist of Iowa State Board of Health; Member of American Association for Advancement of Science; Member of American Public Health Association; Member of American Institute of Mining Engineers; Member of Wisconsin Academy of Science, Arts, and Letters; and Fellow of Iowa Academy of Sciences. Pp. 118. Silver, Burdett & Co., publishers, Boston. 1891.

This book, intended for the use of physicians, sanitarians, and chemists, differs from the majority of works on potable water, in that all analytical detail is omitted. The author gives, in a clear and concise, yet vivid and satisfactory manner, a careful discussion of drinking water, its impurities, and methods of purification.

This work shows that it comes from the pen of a chemist and sanitarian perfectly familiar with his subject, not only from the standpoint of literary attainment, but from laboratory experience as well.

The book is an excellent one, and we heartily recommend it to the earnest perusal of all sanitarians, physicians, and chemists.

J. A. M.

Tables for Doctor and Druggist. Comprising: I. Table of Solubilities. II. Table of Reactions and Incompatibles. III. Table of Doses and Uses of Medicines. IV. Table of Specific Gravities. V. Table of Poisons and Antidotes. Compiled by Eli H. Long, M. D., Professor of Materia Medica, Buffalo College of Pharmacy; Adjunct Professor of Materia Medica, Medical Department, University of Buffalo. Pp. 133. George S. Davis, publisher, Detroit. 1891.

We believe that the author has filled a long-felt want. Physicians and pharmacists, for whom this work is primarily intended, have not the time to search through numberless volumes for the

information gathered in this little book. By this compilation, the author has placed a ready reference in the hands of the workers, whom, we believe, will thoroughly appreciate the work done for them by Professor Long.

We bespeak for it a bright future, and believe that it will not be long before it will be found on the table of every pharmacist and in the library of every physician.

Uses, Tests for Purity and Preparation of Chemical Re-agents. Employed in Qualitative, Quantitative, Volumetric, Dosimetric, Microscopic, and Petrographic Analysis, with a Supplement on the Use of the Spectroscope. By Chas. O. Curtman, M. D., Professor of Chemistry, and Director of Chemical Laboratory in the Missouri Medical College. Octavo, pp. 256, illustrated. John L. Borland, Book and Stationery Co. St. Louis, Mo.: 1890.

This volume will, no doubt, find a hearty welcome in the chemical world.

It contains a vast amount of information, of such a character as to save the busy professional man a great deal of work.

It is an excellent book, and a time saver; we congratulate the author on its production. J. A. M.

BOOKS AND PAMPHLETS RECEIVED.

A Text-Book of Physiology. By M. Foster, M. A., M. D., LL. D., F. R. S., Professor of Physiology in the University of Cambridge, and Fellow of Trinity College, Cambridge. Fourth American, from the Fifth English edition, thoroughly revised, with notes, additions, and two hundred and eighty-two illustrations. Octavo, pp. xvi.—1072. Philadelphia: Lea Brothers & Co. 1891.

Essentials of Bacteriology; being a Concise and Systematic Introduction to the Study of Microörganisms for the use of Students and Practitioners. By M. V. Ball, M. D., late Resident Physician German Hospital, Philadelphia; Assistant in Microscopy, Niagara University, Buffalo, N. Y., etc. With seventy-seven illustrations, some in colors. Saunders' Question Compends, No. 20. Philadelphia: W. B. Saunders, 913 Walnut street. 1891.

Artificial Anesthesia and Anesthetics. By DeForest Willard, R. M., M. D., Ph. D., Clinical Professor of Orthopedic Surgery in the University of Philadelphia; Surgeon to the Presbyterian Hospital, etc., and Lewis H Adler, Jr., M. D., Instructor in Rectal Diseases, Philadelphia Polyclinic and College for Graduates in Medicine. The Physicians' Leisure Library. Single copies, cloth, 50 cents; paper, 25 cents. Detroit, Mich.: Geo. S. Davis. 1891.

Buffalo Society of Natural Sciences, Thirtieth Annual Meeting, June 12, 1891. Containing Addresses of the President, with reports of officers, committees, etc. Buffalo: Baker, Jones & Co., Printers and Binders. 1891.

The Snook-Herr Poisoning. The Official Investigation. Preliminary Examination. By H. M. Goodman, M. D., Demonstrator of Physiology, Bacteriology and Pathology, University of Louisville. Reprint: *American Practitioner and News*, April 25, 1891.

Resection as a Substitute for Primary Amputation. By Thomas H. Manley, M. D., New York City, Visiting Surgeon to Harlem Hospital, New York. Read before the Danbury (Ct.) Medical Society, January 4, 1891. Reprint: *New England Medical Monthly.*

Fractures at the Elbow Joint. By Thomas H. Manley, M. D. Reprint: *The New York Medical Journal*, June 27, 1891.

Tumors of the Naso-Pharynx, Pharynx, Larynx and Œsophagus. By W. Cheatham, M. D., Louisville, Clinical Lecturer on the Eye, Ear, Throat, and Nose, University of Louisville. Reprint: *The New York Medical Journal*, August 15, 1891.

The Administration of Guaiacol Iodide by the Intestines in the Treatment of Tuberculosis of the Lungs. By Wm. H. Gregg, M. D., New York. Reprint: *The New York Medical Journal*, September, 26, 1891.

Remarks on a Series of One Hundred Laparatomies. By Joseph Taber Johnson, A. M., M. D., Ph. D., Washington, D. C., Professor of Gynecology in the Medical Department, Georgetown University; Gynecologist to Providence Hospital; Vice-President of the American Gynecological Society; Fellow of the British Gynecological Society; President of the Medical Society of the District of Columbia in 1887; President Washington Obstetrical and Gynecological Society, 1888-1889; Fellow Southern Surgical and Gynecological Society; Gynecological Surgeon to Columbia Hospital. Reprint: *Virginia Medical Monthly*, October, 1891.

Trachoma and its Treatment. Powdered Jequirity. Written for the *Ophthalmic Record* by W. Cheatham, M. D., Clinical Lecturer on Diseases of the Eye, Ear, Nose, and Throat, University of Louisville.

The Study of Ophthalmic Therapeutics. By F. Park Lewis, M. D., Buffalo, N. Y. Reprint: *The Hahnemannian Monthly*, September, 1891.

My Personal Experience with Vaginal Hysterectomy. By Florian Krug, M. D., New York. Reprint: *The American Journal of Obstetrics and Diseases of Women and Children.* Vol. XXIV., No. 7, 1891.

Four Cases of Removal of Myomata by Abdominal Section. By James F. W. Ross, M. D., Lecturer on Abdominal Surgery, Toronto University; on Diseases of Women, Woman's Medical College; Gynecologists Toronto General Hospital, Toronto Dispensary, and St. John's Hospital for Women. Reprint: *American Journal of Obstetrics and Diseases of Women and Children.* Vol. XLV., No. 9, 1891.

HEALTH BULLETINS.

Michigan Board of Health. September, 1891.

Newport, R. I., Reports of Deaths and Contagious Diseases. September, 1891.

Abstracts of Sanitary Reports, U. S. Marine Hospital Service. Vol. VI., Nos. 35 to 42.

Miscellany.

THE DIOS CHEMICAL COMPANY, of St. Louis, has published a fine lithograph of the uterus and its appendages, showing their anatomical relations in colors. This useful drawing will be sent to members of the profession, free, on application. Address the Dios Chemical Company, 914 Locust street, St. Louis, Mo.

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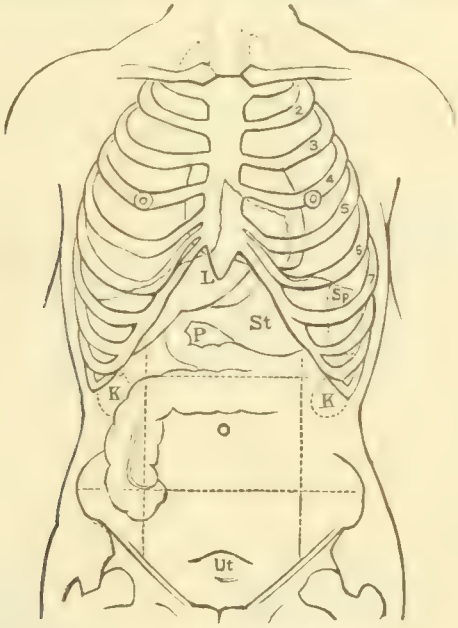

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[Care was taken in preparing these outlines. For example, in this cut, the thorax is from Sappey's great work; the heart and lungs are from the highest authority (Sisson, in *Reynold's System of Medicine*), the liver from Murchison, the pelvis from Stratz, and the whole has been compared with Gray, Quain, Luschka, Hart, and Barbour, and other authorities.—ROBERT L. DICKINSON, M. D.]

every physician. It consists of a rubber stamp, which outlines the several cavities of the body, as well as the eye and ear, so that every case may be recorded in a simple and efficient manner, without taking much time. Anything which economizes

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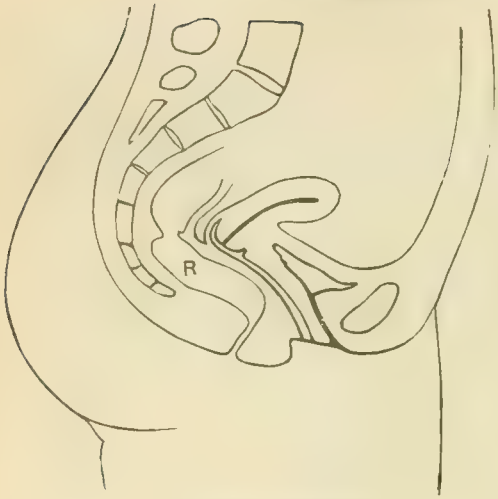

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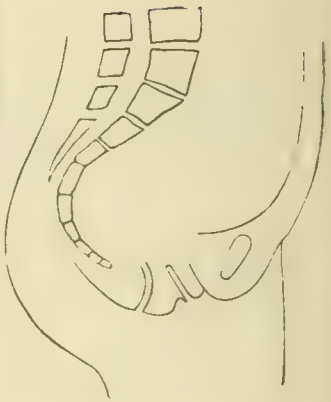

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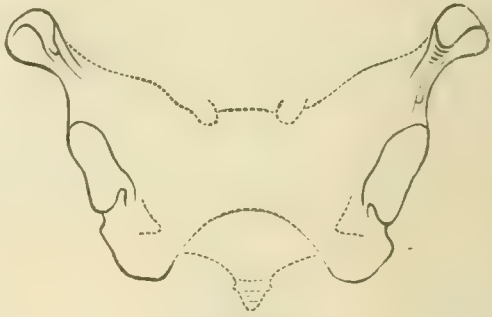
time in the present day is to be commended, but this invention does more,—it adds to clearness as well as conciseness, and becomes at once a valuable addition to the equipment of physicians, whether in general or special practice. We subjoin illustrations which explain themselves. These stamps can be purchased of the manufacturers, by addressing them at 318 Broadway, New York.



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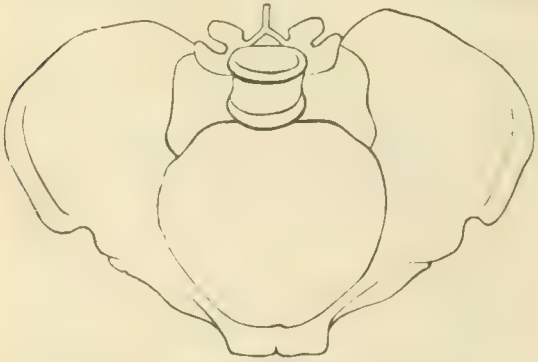

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Messrs. J. B. Lippincott & Company announce for early publication the Life of Benjamin Harris Brewster, by Eugene Coleman Savidge, M. D.

Mr. Brewster took an active and important part in many of the most critical and exciting movements in our recent national history. He knew more or less intimately every American celebrity since the times of Webster and Clay, and his biography will be a valuable contribution to the history of the last half century of our national life. It is especially rich in material relative to the Garfield and Arthur administrations, with which he was associated as prosecuting attorney in the famous Star Route trial, and later as Attorney-General. He will also long be remembered because of his brilliant legal and other oratorical efforts, some of the best specimens of which are given in this volume.

One of the most valuable acquisitions to medical literature of the year will undoubtedly be the new edition of Prof. Roberts Bartholow's Hypodermic Medication, about to be issued from the press of J. B. Lippincott Company. The rapid progress made in therapeutical science since the last edition appeared, has demanded a thorough revision, in the execution of which Dr. Bartholow has largely re-written the work, describing the various new remedies, and giving the latest results of this method of medication. These changes have increased the work by about two hundred pages, and their importance and value will secure even a higher standing for the work as an authority on this branch of medicine. It will be found indispensable to every physician who would keep abreast with medical progress and discovery.

In its November number, the *Cosmopolitan* will publish a series of letters written by General W. T. Sherman to one of his young daughters, between the years 1859 and 1865, and covering most of the important events of the war of secession. These letters present graphic pictures of a great soldier amid some of the stirring scenes in which he was a giant figure, and in them the patriotic spirit of the Federal general is seen to have been most attractively tempered by a strong affection for the Southern people. The fraternal feeling which glows in these letters is in refreshing contrast to the sectional bitterness which characterized the period, and they will constitute an interesting and important contribution to the literature of the war.

Johnson & Johnson, of New York, have published a compilation of recent notes and suggestions from eminent surgeons on the Modern Method of Antiseptic Wound Treatment. This is an octavo pamphlet of forty pages, illustrated, and contains much valuable information for the profession. It will be furnished on application by this well-known house.

The second volume of Hermetic Philosophy, by Styx, of the "H. B. of L.," will soon be issued from the press of J. B. Lippincott Company. As in the preceding volume, it includes lessons, general discourses and explanations of Fragments from the schools of Egypt, Chaldea, Greece, Italy, etc., and is a continuation of the line of thought so ably treated in that work.

Preserving the Complexion.—A great deal can be done towards having a fine and smooth complexion, by a systematic treatment of rubbing, says *The Ladies' Home Journal.* A fine towel or a bit of red flannel are the best for rubbing, twice a day, or four times, if rapid results are to accrue. By degrees — as the skin gains tone and elasticity from having thrown off the waste matter in its ducts that kept it clogged, sickly, and flabby — the friction can increase in energy. The skin becomes not tougher, but more resistant. If the rubbing is too hard at first, however, it is liable to produce redness and pimples. Even slight friction will do this at times on an unaccustomed skin. But the treatment should be persevered in nevertheless, and the skin soon becomes extraordinarily fine and smooth.

Wanted—The Berlin Royal Library wishes to complete its file of the Buffalo Medical and Surgical Journal and advertises for Vols. I. to XXVIII. inclusive, of the new series, and the fifteen volumes of the old series. All inquiries on the subject of back numbers and prices should be addressed to the Managing Editor, 284 Franklin street, Buffalo, N. Y.

For sale—Valuable Medical Library and Surgical Instruments for sale cheap. Address, Mrs. B. A. Fuller, LeRoy, N.Y.

Notice to Contributors. — We are glad to receive contributions from every one who knows anything of interest to the profession. Articles designed for publication in the Journal should be handed in before the first day of the month. The Editors are not responsible for the views or opinions of contributors. All communications should be addressed to the Managing Editor, 284 Franklin Street, Buffalo, N. Y.

Buffalo Medical and Surgical Journal

Vol. XXXI. DECEMBER, 1891. No. 5.

Original Communications.

A DISCUSSION OF APPENDICITIS.[1]

FIRST PAPER.

A REPORT OF CASES OF APPENDICITIS: WITH REMARKS

By JOSEPH PRICE, M. D.,

Physician in charge of the Preston Retreat; Fellow of the American Association of Obstetricians and Gynecologists.

The first case I report from memory. It occurred in Ohio eleven months ago.

Case I.—A physician telegraphed me that he had a case of appendicitis of two weeks' standing, and asked me to come at once. I wired him that I would return by way of his city in five days. He permitted the man to remain quietly in bed. I saw him at the end of the twenty-first day, leaking, with a rapid, feeble pulse, and, I think, a subnormal temperature. The patient was twenty-seven years old, and previously had been a vigorous man. The abdomen was greatly distended, and there was marked fluctuation on both sides below the umbilicus. There seemed to be a perfect inflammatory diaphragm at that point. He was placed on the table, a lateral incision made, and two gallons of muddy, pussy fluid escaped. The irrigator, twelve inches long, passed its full length, extending to the left iliac fossa. Two pitchers of water were used, and two large gauze drains, with a glass tube between them, were also used. No stitches were placed. The patient was put in bed, and made a rapid recovery.

Case II.—Mrs. L., aged thirty-two years; married eleven years; no children; no miscarriage; patient of Dr. John T. Hampton. Appendicitis with perforating ulcer of cecum; multiple pus pockets; extensive adhesions to omentum, large and small bowel. Appendix removed. Perforating ulcer of cecum freshened as in vesico-vaginal fistula and closed; stump of appendix inverted; irrigation and drainage, with

1. Papers read at a Special Meeting of the Philadelphia County Medical Society, September 28, 1891.

speedy recovery. This patient had suffered recurring attacks, was greatly emaciated, feeble pulse, and slight elevation of temperature. She has gained over thirty pounds since the section.

Case III.—Mr. H., aged forty-two years. Operation May 5, 1891. A pint of foul pus, fecal in odor; omentum and adherent loop of ilium; irrigation; two tubes used in drainage; gauze drains. Discharged May 29, 1891.

Case IV.—Mrs. N., aged twenty-five years. Eleven weeks since confinement. Operation July 4, 1891. Appendicitis of eleven weeks' standing. Appendix removed. Adhesions to cecum, bladder, and uterine walls, all freed. Irrigation and drainage. Patient discharged August 6, 1891.

Case V.—Mrs. S., aged thirty years; married eight years. Painful, irregular, and profuse menstrual history; confined to her bed for the past fifteen months. Appendicitis, with double pyosalpinx. Operation July 6, 1891. Removal of appendages and vermiform appendix; cyst of left ovary size of orange; universal adhesions separated; bowel stitched; six inches of ileum coiled and firmly adherent to uterus, bladder, and sigmoid. Left tube discharging through ileum; copious irrigation; glass and gauze drains. Discharged August 6, 1891.

Case VI.—Miss W., aged twenty-eight years. Year previous had nephritis and cystitis; later had severe pain in right and left ovarian regions, paroxysms becoming more severe and frequent; pain at micturition and stool; catamenia gradually of shorter duration; loss of appetite and insomnia. Operation August 20, 1891. Appendicitis and double pyosalpinx. Cyst of left ovary size of hen's egg; cyst of right ovary size of orange; adhesions universal. Appendix, distended by concretions and two drachms of fluid, firmly adherent to ileum. Clean removal of appendix and uterine appendages; irrigation and drainage. Discharged September 19, 1891.

Case VII.—C. V., aged thirty-two years; married eight years; seven children; Polander by birth; resident Lucerne county, Pa. Last confinement, January, 1891. Acute mania, no assignable cause: probably puerperal. Indications of abdominal trouble for some time; went to bed July 23d with pain, tenderness in right iliac region; tympanitis. Section August 14, 1891. Multiple pus sacs and extensive adhesions to omentum, ileum, bladder, and uterus; the pus pockets extended from cecum to bladder. Appendix completely disorganized and floating in a pool of pus; freeing of all adhesions; irrigation and drainage; stump of appendix inverted; stitching of ileum and cecum at disorganized points. She did fairly well for five days; died the sixth day. Post-mortem: Intestines in neighborhood of operation quite gangrenous; a general peritonitis. A large quantity of fetid pus in enlarged right inguinal canal; also in pocket between bladder and uterus.

Nomenclature.—The old terms were arrived at by examining old, neglected cases, often post-mortem. Recently but one term—appendicitis—is used before laparatomy, before post-mortem, because those two performances prove that so far as the gravity, intensity, and extent of the disease are concerned, the symptoms are unreliable and inadequate; further, abdominal sections and post-mortems have determined what the treatment should be—that is, surgical—under a surgeon from its inception; hence the name indicating and impressing the nature of the disease and the character of the treatment—that is, appendicitis surgicalis. Idiopathic peritonitis indicates nothing; it is an empty term.

The terms typhlitis, perityphlitis, paratyphlitis, extraperitoneal abscess of the right iliac fossa, are useless except to indicate a secondary or late process, originating, without exception, in inflammation of the vermiform appendix.

Symptoms.—The most constant and valuable signs are:

1. History of sudden onset.

2. The point of greatest sensitiveness to pressure, exactly localized over the base of the appendix.

3. Fever as indicated by the thermometer varies, usually low.

4. Rigidity of right abdominal muscles, constant.

5. Constipation.

6. Edema, overlying a deep abscess, in the right iliac fossa in neglected cases.

7. Shock, more or less profound, usually occurs where perforation happens early and suddenly; it is followed by chill, vomiting and collapse.

There are no special signs of perforation if it takes place late, after adhesions have formed. If perforation occurs late, and the adhesions are imperfect, we find shock.

The symptoms should be studied most carefully at the end of the first twenty-four hours.

8. Pain is misleading; often referred to epigastrium alone; to umbilical region sometimes; it is often slight.

9. Tympanitis is variable; it depends on the state of the bowels; it indicates intestinal paresis—if it comes on rapidly it is unfavorable; it is often the result of opium.

10. Percussion not necessarily dull; there may be a tympanitic note from gas in an overlying intestine.

11. Over-extension of right thigh gives pain.

12. Cough is avoided.

13. Tumor inconstant the first two days.

14. Pulse indicates severity and increase; it shows constitutional disturbance.

15. Chill and vomiting inconstantly accompany the initial pain.

16. A prodromal stage of abdominal discomfort (about a week) is frequent.

17. Flexion of hip-joint not marked except in neglected cases.

The symptoms are not commensurate with the gravity, intensity, or fatality of the disease.

Diagnosis.—Early diagnosis is of the greatest importance in reference to treatment and result.

1. Find with tip of finger—using firm pressure—point of sensitiveness (exact point of greatest sensitiveness); it will be in an adult one and a half to two inches inside the right anterior superior spinous process of the ileum, on a line drawn from that process to the umbilicus—in children, according to size, less distant from the spine of the ileum. (McBurney, confirmed by Weir and others.)

2. Rectal examination is of no value early.

3. Difficult to diagnosticate the first twenty-four hours, because few symptoms present.

4. Subjective pain is of little or no value.

5. Constitutional symptoms are far inferior to local signs in forming an accurate diagnosis.

6. Have patient cough.

7. The hypodermic needle should never be used as an aid to diagnosis.

8. Medical men (physicians) no longer diagnosticate these cases—in the start—as simple obstruction of the bowel.

9. Diagnosis by exclusion is the only safe method.

10. The important points—after the disease has been pronounced appendicitis—is to diagnosticate it as an operative or a non-operative case.

Points in deciding operative or non-operative character of the case:

1. Do not operate on the first day—usually—because the number of mild cases is undoubtedly large. One operator (McBurney) saw thirteen cases in one year, too mild for operation.

2. If nausea disappears in twelve hours; if tenderness on pressure not increased in twelve hours; if temperature normal, or not above 100° in the mouth; if pulse normal or but little accelerated; if patient moves in bed with ease;—recovery without operation probable.

Prognosis.—No positive prognosis can usually be given in the first twelve hours. If we wait for "strong evidence" of perforation, abscess, general peritonitis, rapid, weak pulse, anxious respiration, distension of abdomen, though the operation is made, the patient will not recover.

Surgery has sometimes been successful even where there has been—

(*a*) General suppurative peritonitis;

(*b*) Septic paresis of the intestines;

(*c*) Multiple abscesses in the peritoneal cavity.

Such cases as these, however, usually die, and are classed as hopeless.

Where there is no exhaustion, no general sepsis, no debility from long abstinence from food, no prolonged vomiting, the prognosis is good.

It is a serious, often a difficult, operation.

"Abscess, wherever it is, and however well it may appear to be surrounded by protecting plastic deposits, is a constant menace to life, as evidenced abundantly by its spontaneous opening into the abdominal cavity, the venous canals, the bladder, and the chest cavity, as well as externally and into the intestinal canal." - *Prof. Bridge.*

Pus will form whether there be perforations or none; 145 autopsies had pus (Matterstock); 125 autopsies showed pus (Fenwick, quoted by Keen); 100 autopsies had pus (Weir, quoted by Keen).

Sepsis is hopeless for medicine, and nearly hopeless for surgery.

Sepsis begins before the end of the third day as a rule.

Death from sepsis on the third, fourth, and fifth day is the rule.

The prognosis as to day of death, without operation, in perforative cases is: one-third die between the second and fifth day.

Proof of 176 cases: Eight cases died on the second day; twenty-eight cases died in first three days; forty-six cases died in first four days; sixty cases died in first five days. (Fitz.)

Experience shows no danger existing of infecting the healthy peritoneum in the course of an operation on the appendix.

Essentials of operative success external to the patient.—For success the operation requires certain conditions external to the patient, namely: 1. General surgical skill. 2. Good assistants.

Time of operation.—"No cases in surgery, saving, perhaps, hemorrhage from large wounded vessels, require more prompt interference" (surgical).—*Keen.*

But one out of twenty-three early laparatomies died. (McBurney.)

"By waiting till the seventh, eighth, or ninth day to operate, a majority only, all more or less dilapidated, will have passed many dangers; not a few will be waiting the knife, that they may start on the road to recovery."

Operate early (before sepsis begins), says one of wide experience, so the operation may not be an autopsy.

Not, however, on the first day, generally speaking. At the end of thirty-six hours, if a tumor has formed, or if symptoms indicate increase in severity or extent of the disease. Before thirty-six hours, if sudden perforation.

If collapse or shock should be very profound, there may be need to stimulate and wait for reaction before operating.

Statistics of time of early operations: Twenty-four cases (early laparatomies), six done on second day; fourteen done on third day; two done on fourth day; two done at the end of one week. Result, twenty-three recoveries, one death. (McBurney.)

Definition of early operation.—"By early laparatomy is meant operation before the pathological process has reached an advanced stage. It is not measured by time; it is before (1) general septic peritonitis has begun; (2) before pus flowed freely into the pelvis; (3) before complete septic paresis of intestines has set in."

An early operation is done at a time when the removal of an actually diseased appendix is capable of putting an end at once to an active disease, which has already become clearly defined, and which threatens life.

Origin of early operation.—"The early stage operation, or the operation for recurrence, if not of exclusively American origin, has been developed and established by American experience," is true.

Kinds of incisions.—A choice is to be made as to the kind of incision—that is, between, first, a free opening into the general peritoneal cavity, and, second, an opening limited to evacuation of the contents of an abscess without exposure of the peritoneum.

When to use the different kinds of incisions.—The free opening into the general peritoneal cavity is used (1) in quiescent state after recurrent attacks; (2) in early stage of progressive attacks, with or without abscess or general peritonitis; (3) in later stage, when abscess has formed in one of the rarer positions, and is not adherent to anterior abdominal wall.

The "limited opening" is done in the later stage of the affection for simple evacuation.

Sites for incision.—There is a choice of site for free incision as follows: (1) median line below umbilicus (Gerster); (2) outer margin of right rectus muscle below level of umbilicus (Sands).

There are several places at which the "limited incision" may be made; they are (1) parallel to Poupart's ligament, about one inch above it, to above and beyond anterior spine of the ileum (Willard Parker's oblique incision); (2) through floor of iliac fossa; (3) through rectum.

When the different sites are to be chosen. The median line is chosen as a site for the incision in cases of doubtful diagnosis for special indications. The lateral incision is generally chosen for early operations. The oblique incision is made for well-developed abscesses, mainly adherent to the anterior abdominal wall (Réclus).

Advantages of the different incisions. The lateral incision is preferred, because (1) it lies directly over the root of the appendix; (2) it exposes the field of operation more favorably than the median; (3) it creates a shorter, a less exposed, line of drainage.

The advantages of the median incision are, (1) greater probability of not encountering adhesions between the anterior wall and the intestines, in the line of incision; (2) easier access to all parts of the peritoneal cavity for washing and for drainage.

Instruments.—Of the instruments to be used, there are but those needed in other major operations.

Adhesions, limiting. Adhesions make appendicitis a local, circumscribed disease: make it an intra-peritoneal disease generally, *i. e.*, nearly always. When they are absent, a diffused mischief is the consequence.

Adhesions prevent resolution. They are left by an attack that apparently ends in recovery; render resolution an absurd term.

Adhesions cripple organs or parts.—They may bind appendicitis to (1) parietal peritoneum; (2) omentum; (3) intestines; (4) vessels; (5) itself; (6) in short, to any and all surrounding structures.

Adhesions cause new trouble.—When slightly provoked, they set up new trouble.

Adhesions cause strangulation.—They lead to strangulation of omentum, bowel, etc.

Adhesions, frequency of.—Thirty-five per cent. of all post-mortem examinations made show them. (Toft).

Of 26 cases 6 cases had no adhesions, 6 cases had slight adhesions, 6 cases had marked adhesions—that is to say, 76 12-13 per cent. of the 26 cases had slight, medium, and marked adhesions. (Weir.)

Adhesions, treatment of.—Free adhesions by finger.

Treatment, by whom.—The physician shares responsibility with the surgeon as early as possible. From the inception of the disease, through the operation to the end, the surgeon and physician should not be separated; they should see the case together.

Treatment, washing.—It has been asserted that hot water is (1) not stimulating; (2) not cleansing in irrigation; (3) its use soon followed by depression, marked; (4) its contact with the peritoneum injurious; (5) that sponging is more quickly done than irrigation; that, it being impossible to cleanse hands with soap, water, brush, "rinsing (irrigation) is ridiculous." The above statements are false.

Treatment where pus is found.—If pus is found in open pockets, wash out abscess cavities, seek appendix, tie, cut off, invert, cover with or by Lembert's sutures through the outer layer of cecum, pack space between incision and abscess with gauze and iodoform, drain by rubber tube or rubber and glass: partly close wound, withdraw packing from between intestines on first and second day: withdraw tube and remainder of packing when circumstances indicate.

Treatment, counter-drain.—Counter-opening for drainage in flank, above crest of ileum, or through rectum, or where a sinus.

If little trouble found. The removal of a but slightly diseased appendix cuts off the possibility of a recurrence, and is a good thing.

Where nothing found, i. e., an exploratory operation. "Exploratory operations will result in fewer deaths by far than the expectant delay which has heretofore been the general rule." (Keen.)

Exploratory operation "carries with it less danger than the disease"; it has but few risks.

Treatment of stump.—To sear mucosa of stump with pure carbolic acid or Paquelin's cautery is lowering an already devitalized part.

To ligate appendix: Invaginate stump, and suture after Lembert, is a good way.

Site of origin.—The disease originates in the appendix. (McBurney and McMurtry.)

Seat of Perforation.—The point of perforation is usually at the free end of the appendix; sometimes the whole part is amputated.

Perforation, frequency of.—Of 146 cases (Matterstock), 132 cases (60 per cent.) had perforations; of 129 cases (Fernwick), 113 cases (86 per cent.) had perforations; of 100 cases (Weir), 34 had perforation; 200 per cent. of Kümmel's cases had perforations.

Cause of appendicitis.—The causes of appendicitis are: 1. Irritating substance, as foods, concretions, foreign bodies. 2. Congenital stricture, occasionally. 3. Strictures at the proximal end, due to ulcerations.

Concretions, fecal, frequency of.—Of 146 cases (Matterstock), 63 had fecal concretions; of 8 cases (Stimson), 1 had fecal concretion.

Size of foreign bodies that may enter Gerlach's valve.—Foreign bodies must be small to pass Gerlach's valve and enter the appendix, thus: a cherry-pip may pass with difficulty; a plum-stone may not enter. And autopsies teach surgery.

Multiple pus cavities.—That there are frequently multiple pus cavities, proof: one case (Mikulicz) had 6 pus pockets, opened by three incisions; another of his cases had 3 pockets, which were opened by incisions.

Ileo-cecal abscesses.—They also show ileo-cecal abscess. Proof: of 106 cases (Krafft), 84 had autopsies, 84 had ileo cecal abscesses.

Points at which cysts or abscesses of appendix may empty.—They prove that the abscesses or cysts do and may empty (*a*) into the abdominal cavity; (*b*) into cecum through Gerlach's valve; (*c*) into rectum; (*d*) through Pettit's triangle; (*e*) above Poupart's ligament; (*f*) into ischio-rectal fossa; (*g*) into a coil of intestine; (*h*) through crural ring; (*i*) into a venous canal; (*j*) into esophagus; (*k*) into lung.

Progress of appendicitis.—They (laparatomies and autopsies) show three distinct panoramas of progress in the disease.

Picture 1 of progress.—(*a*) Irritating substance, catarrh of cecum, or appendix, or both, dilatation of appendix primarily or following dilatation of cecum, contents of bowel enter appendix, fluids are absorbed, solids are left, concretions are formed, and act as mechanical causes for inflammation, and ulceration, upon which follows either amelioration, or relapse, perforation, sepsis more or less extensive, operation or death.

Picture 2 of progress.—(*b*) Irritation, catarrh of cecum or appendix, or both, gangrene, obliteration or ulceration, stricture of

proximal end during healing of ulcers, distal end patulous, retention sac or cyst forms, which inflames, which empties into cecum, rectum backward, peritoneal cavity, etc.; peritonitis arises, adhesive or local, or universal; quiescent; recurrence; connective tissue becomes involved, omentum, intestines, etc., fixed by adhesions and possible strangulation of omentum, intestines; knife, ligature, irrigation, and drain, must be used or death occurs.

Picture 3 of progress.—(*c*) Foreign body; pressure, atrophy, necrosis of epithelium, ulceration, perforation, etc.; knife and its associates, or death.

Kinds or classes of appendicitis.—The post-mortem, and the section, show variations in the late or secondary process of appendical inflammation, which have been classified variously.

Professor With subdivides the disease as follows: 1. Peritonitis appendicitis adhesivus. 2. Peritonitis appendicitis localis. 3. Peritonitis universalis. His classification has been largely endorsed, and is recognized under slightly changed names.

Bull distinguishes between (1) catarrhal perityphlitis and (2) suppurative perityphlitis.

Mikulicz classifies it as (1) diffuse septic peritonitis; (2) progressive fibro-purulent peritonitis.

Keen makes five classes, according to progress: 1. Mild form, without perforation, usually no abscesses. 2. Perforative, (*a*) severe, early, fulminant; (*b*) mild, early, suddenly bursts, etc. 3. Perforative, with comfortable abscess, rupturing into hollow viscus, or operated upon. 4. Abscess forming slowly, chronic, weeks, months, years. 5. Recurring.

The sum of all is (McBurney) operative, and non-operative, appendicitis.

Previous attacks.—Of 106 cases (Krafft), 24 had previous attacks in 1 to 20 years; 23 per cent. had previous attacks.

Number of attacks.—One case (McBurney) had 12 attacks in one year. One case (Treves) had 14 attacks.

Frequency of the disease.—35 per cent. of all post-mortems show residua of appendicitis; 36 per cent. (over one-third) of 300 autopsies done at random, revealed diseased appendix (Toft). One case of perityphlitis to 100 of appendicitis (McBurney). Assume that one-third or more of all adults have one or more attacks (Keen).

Sex most frequently attacked.—Of 14 cases (Mynter), 1 was a woman; of 24 cases (McBurney), 21 were males, 3 females.

Age at which it most frequently occurs.—Of 72 cases (Matterstock), 2 were under two years; 10 were between two and five years; 25 were between five and ten years; 35 were between ten and fifteen years. Of 228 cases (Fitz), 173 cases were below thirty-one years; 207 cases were under forty-one years. Of 24 cases (McBurney), 24 were under thirty-six years. Of 14 cases (Mynter), 1 was under twelve years. Hence it is a disease of early life.

Results. The operation can be done by different individuals under varying conditions, with something like uniform success; proof, the work of Sands, Stimson, Weir, Bull, Senn, Morton, Treves, Hartley, Mynter, Dalton, McBurney.

Medical and conservative mortality.—Mortality under conservative treatment is large, larger than statistics can prove, for in many fatal cases the origin is unsuspected. Proof: Fitz puts it at 26 per cent.; Stimson puts it at 25 per cent. Of 72 cases, 74 per cent. recovered (Fitz). Of 72 cases about 36 were treated medically, and 11 per cent. died, and 14 per cent. spontaneously evacuated the pus late (Fitz). In medical cases the mortality is now 44 per cent.

Mortality from early laparatomy.—Of 24 cases of early laparatomy (McBurney), 23 recovered, 1 died. Of 35 cases of early operation (Weir), 34 recovered, 1 died.

Mortality from delay.—For one operation done by mistake ten deaths can be shown from waiting for signs of tumor or peritonitis.

Acute mischief after quiescence. Of 30 cases of acute perforative appendicitis, where recurrence was noticed, 22 cases exploded into abscesses or general peritonitis before the third attack; one case so exploded after the fifth attack.

Value of medical treatment.—Medical treatment *i. e.*, rest and intelligent nursing—is of twofold value: First, in limiting the extent; second, in shortening the duration of mild attacks.

Items of interest. Avoid deep epigastric artery and vein in making lateral incision.

A point in identification.—The anterior bundle of unstriped muscles on the colon, which terminates at the base of the cecum, is in sight; it is a good guide to the appendix.

Abnormalities.—Anatomical relations of the appendix are sometimes abnormal; it was once found to the left of the median line, above the umbilicus, with a short mesocolon.

What is recovery without operation?—Recovery without opera-

tion means relief from recurrent pain, and thereafter an improved condition of health for a longer or shorter time (Weir).

Definition of obliteration of appendix.—Obliteration of the appendix is narrowing of the appendix, which often follows catarrh of the part.

Percentage of obliteration of appendix.—Of 26 cases, 10 gave obliteration.

Why arrays of statistics?—The object of bringing statistics, percentages of recoveries, etc., before physicians, is that they may realize the importance of prompt operation (Vander Veer).

Where Pettit's triangle.—Pettit's triangle is between the latissimus dorsi and the external oblique muscle.

Period of activity in literature of appendicitis.—Much has been written on appendicitis in the last twelve years (1879 to 1891).

Period of active work in appendicitis.—Much work in appendicitic trouble has been done in the last two years (1889 to 1891).

Literature.—Buffalo Medical Journal, 1879; Transactions of American Surgical Association; Volkmann's Klin. Vorträge, January, 1889; Annals of Surgery, October, 1889; New York Medical Journal, October 25, 1890; Transactions of Medical Society of the State of New York, 1891; Transactions of American Physicians, 1886; Medical and Surgical Reporter, February, 1886; Medical News, March 1, 1890; Lancet, 1889.

The above articles have been read and others in preparation for this paper.

Some of those to whom this article is indebted, and who have largely contributed to the biography of appendicitis, are the following: Drs. Abbe, Buck, Bull, Dalton, Ebebohls, Fenwick, Fowler, Fitz, Gerster, Hartley, Hektoen, Holgh, Hadra, Holmes, Krafft, W. W. Keen, Lange, Morton, McBurney, McMurtry, Mikulicz, Mynter, Matterstock, Mackenzie, Murray, Monks, Porter, Parker, Regnier, Réclus, Roux, Senn, Stimson, Lewis Smith, Sands, Greig Smith, Teale, Tait, Toft, Treves, Vander Veer, With, Weir, and Wyeth.

SECOND PAPER.

FOUR OPERATIONS FOR APPENDICITIS: THREE RECOVERIES; ONE DEATH FROM A VERY SMALL CONCEALED ABSCESS.

By W. W. KEEN, M. D.

Professor of Principles of Surgery, Jefferson Medical College.

CASE I. *Recurrent appendicitis; operation after the fifth attack (with perforation and general peritonitis), by median and lateral incisions; recovery.* Miss B., aged thirty years, a slender, frail woman. A year ago she developed a moderate lateral curvature of the spine through muscular weakness. Her father died of cancer of the bowels; her mother is living, and is even more delicate than herself.

About fifteen years ago she had her first attack of perityphlitis. A few years later a second occurred, and about six years ago a third, which was the first in which I saw her. The attack was not severe, no suppuration followed, and after its subsidence she seemed as well as usual.

On May 31, 1890, she was suddenly taken with severe paroxysmal pain in the lower part of the abdomen, accompanied by vomiting. The attack was attributed to the eating of some strawberries, and when the bowels were subsequently moved by small doses of calomel, a quantity of strawberry seeds was passed. The pain was relieved by morphia. There was slight general tenderness, not limited to the right iliac fossa. The temperature only rose to 101°. The attack gradually passed away, and in two weeks she was able to return home. For the account of this attack I am indebted to Dr. W. H. Morrison, who attended her. The symptoms rather pointed in his mind to an ordinary intestinal colic from the fruit, though, as there had been prior attacks of perityphlitis, the right iliac fossa was watched with some care; but no special dulness or tenderness existed there, nor was there any induration. There had been no chill.

The summer of 1890 was passed in comparatively good health. As soon as I returned from my summer holiday, I was asked to see her by my assistant, Dr. W. J. Taylor. He had diagnosticated not only a renewed attack, but also a probable perforation of the appendix, on the day of my return. She had been constipated for several days, and a slight movement of the bowels on September 30, 1890, due to divided doses of Epsom salt given the previous evening, was followed by symptoms of peritonitis over the entire lower abdomen, the tenderness in the left iliac fossa being possibly even more marked than in the right. The induration was only moderate. Exploration by the rectum revealed general tenderness of the pelvic viscera, with diffused induration, but no fluctuation. A vaginal examination could not be made. It was

clear that perforation had taken place, and that immediate operation was needful.

When I first saw her on the evening of October 1st, the symptoms, while clear, were not very urgent, and Dr. Taylor and I felt it safe to postpone the operation until the next day, and so avail ourselves of daylight. The peritonitis was clearly local in the pelvis and lower belly; it did not involve the entire peritoneum, and the depression and shock were not so great as to require instant interference.

Operation, October 1, 1890. The hair was shaved and the field of operation thoroughly disinfected. In view of the involvement of both iliac fossa, I deemed it best to make an incision in the middle line. As soon as the abdominal wall was penetrated, pus began to exude very abundantly, and I estimated that over a pint escaped. The omentum was glued to the belly wall, and the pelvic viscera, including the intestines, were all glued together by adhesions, except where they were separated from each other by pus.

The appendix was at once sought for. It was firmly bound in place, as thick as a good-sized thumb, and so turgid that it was erect. It could not be brought to or even near the opening, and accordingly another oblique incision was made in the right iliac fossa, through which it was approached very readily. As soon as seen it was discovered that there was a small opening at its tip, through which the intestinal contents were escaping. With some little care it was freed from its adhesions, tied one-fourth of an inch from the cecum, and removed. The stump was then disinfected and invaginated into the bowel, the peritoneal coating of which was secured by four Lembert stitches. The entire abdominal cavity was then thoroughly flushed with hot water. Two drainage-tubes of glass were inserted, one in each incision, and the wounds closed. I sought to carry the drainage-tube in the middle line into Douglas's cul-de-sac, butthis could not be found, as it was obliterated by adhesions. The drainage-tubes were emptied by a long-nozzled syringe whenever full.

December 17, 1890. In twenty-four hours after the operation, without laxatives, her bowels were moved twelve times, and for a week afterward from two to four or six times a day, in small quantities, semisolid. The bladder was emptied most of the time by catheter. Her temperature, which two days before the operation had reached 103°, fell immediately after the operation to 101.6°, and four days after the operation had reached the normal. By the end of a week it had gradually climbed again to 102°, and on that day she had a severe "sinking spell," with much pain, cold perspiration, and excessively weak pulse. This was met by prompt administration of stimulants and digitalis, and in forty-eight hours her temperature had fallen about two degrees. Meantime her bowels continued to trouble her very greatly, with pain and frequent movements. Examination by the rectum showed the pel-

vic viscera to be matted together in a hard mass, which pressed upon the rectum and gave great annoyance. Until the eighteenth day after the operation her temperature fluctuated very markedly from normal or a little above to 101° to 102°, but on the nineteenth day, coincidently with the improvement in her bowels, her temperature sank to normal and remained such during the remainder of her convalescence. In fact, most of the time it was half a degree below normal.

Meantime the median wound gaped open to the extent of over an inch in consequence of the sloughing out of the stitches, but by the time it had gaped open a layer of granulation had sprung up on the omentum, which lay at its bottom, and without any interference other than the daily redressing,—sometimes several times a day, when the discharge was considerable,—it slowly healed, and by the end of five weeks was entirely closed by a firm cicatrix. The drainage-tube was removed at the end of ten days, when there was no further discharge through it. The lateral wound healed without incident at the end of ten days.

After the lapse of three weeks from the operation her progress was slow, but steady. A month after the operation she first sat up out of bed.

September, 1891. There is a slight tendency to a ventral hernia at each incision, for which she uses a binder. Her menstruation is regular and not especially painful. Examination of the pelvic viscera by the rectum shows them to be mobile and free from adhesions.

Case II. *Perforative appendicitis of a week's duration; temperature of only 99° in spite of a large abscess; operation; recovery.* H. T., male, aged forty-two years; admitted to the Jefferson College Hospital, February 11, 1891, at the request of Dr. C. M. Ellis, of Elkton, Md. Family history negative. He was taken ill on February 4th with pain all over the belly. This was not located in the right iliac fossa until two days later. His fever had run up to 102° and 103°. There was tumefaction in the right iliac fossa, but no edema. There was resistance to touch, parallel with Poupart's ligament, and filling up half of the space between Poupart's ligament and the umbilicus. The point of greatest tenderness was one inch below McBurney's point. On the evening of his admission his temperature was only 100°, and was no higher the next morning. On the evening of the second day, however, the temperature rose to 101.2°, falling the next morning to 99°. Finding that the vesperal rise of temperature continued, and that a week had elapsed, I determined at once to operate. This was done in the public clinic.

An oblique lateral incision was made parallel to Poupart's ligament, which immediately liberated a large quantity of very foul smelling pus. The appendix was found to be swollen to about the size of the thumb, with a distinct perforation of the diameter of a knitting-needle at its

extremity. The appendix was tied and cut off. A second smaller abscess cavity was found at a deeper level than the first, the pus from which was much more fetid than that from the first. The cavity was then thoroughly washed out with a sterilized salt solution, a drainage tube was inserted, and the centre of the incision united by a few stitches. Practically, these might well have been omitted, for at the end of three weeks, in order to secure free drainage of the wound, it was necessary to lay open this adherent skin. He went home with a small, almost healed ulcer, nine weeks after the operation. The highest temperature was 102.2°, on the sixth day.

CASE III. *Appendicitis from a fecal concretion; pus in the general peritoneal cavity; operation ninety to ninety-six hours after inception of the disease; recovery.*—J. S., a French lad, aged nineteen years. Admitted to the Jefferson College Hospital, February 28, 1891. Four days before this he was in perfect health, and at his work as a waiter in a restaurant. He had never had a similar attack. On that day he was seized with cramps all over the belly. By the next day the pain had become fixed in the right iliac fossa, and I was called to see him on the morning of the fourth day by Dr. J. C. Wilson, who had been called in on the previous evening. When I entered the room the tears were rolling down his cheeks, and he was groaning and writhing with pain. The bowels had been opened on the day of the attack, but not since. On the evening of the third day the temperature was 103°, and on the morning of the fourth day 101°. There was tumefaction parallel to Poupart's ligament, about three fingers' breadth in width, and the anterior wall of the belly and right side was tense, elastic and resistant to the touch. It was extremely tender, and he indicated by one finger the tenderest spot at McBurney's point and one inch below it. The right leg was flexed to relax the belly wall. There was dulness on percussion, and a rectal examination showed considerable induration and obscure fluctuation. There was no edema. There had been no vomiting.

As quickly as possible arrangements were made to operate, and the operation was done before the class two hours after I first saw him with Dr. Wilson, as nearly as could be determined, between ninety and ninety-six hours after the attack. The incision was parallel to Poupart's ligament. Although there was no external edema, as soon as I cut through the aponeurosis of the external oblique, there was marked edema of the tissues beneath this aponeurosis. At a greater depth a quantity of extremely fetid, very thin pus gushed out, and on washing out the cavity with a salt solution, I found an evidently gangrenous mass, with a knobbed free end, which looked like the appendix bound down by adhesions. A piece of the omentum was attached to it, and the appendix was distended, but clearly not perforated. It was ligated

and cut off. Upon opening the amputated portion, I found a fecal concretion as large as a bean. So far as gentle manipulation could determine, there seemed to be no adhesion of the bowels to each other, and apparently the pus was contained in the general peritoneal cavity. This was well washed out with hot water and closed, and a drainage-tube was inserted. The patient made a rapid recovery without any serious complications whatever, improving from the very moment of the operation. He went home in three weeks entirely well.

CASE IV. *Perforative appendicitis; pain below the ribs; laparatomy; death; concealed small abscess behind the colon.*—Mrs. F., American, aged thirty years, was first seen at 11.30 P. M., June 27, 1891, with Dr. Seitz. She had married at fifteen, and has had four children, – the last, three years ago. She has been perfectly regular, the last sickness coming on a week too early, ten days ago. A week ago she was suddenly seized with violent pain just below the right border of the ribs. A day or two later one of her children struck her accidentally over the same spot, producing intense pain. Five days ago she was seized with an aggravation of the pains, and was in such a condition of collapse that Dr. Seitz feared she would die. Her temperature was below 97°. Active stimulation soon relieved this, but the pain continued almost as severe as before. Another attack of collapse today, with cold extremities up to the knees and elbows, induced Dr. Seitz to call me in consultation. I found a slender, delicate-looking woman, with the right leg drawn up and the right side of the abdomen excessively tender, with the muscular wall of the belly very tense. The slightest touch on the entire right side of the abdomen produced the most severe pain. On the left side moderate pressure was pretty well borne. The pain was most severe just below the border of the liver, diminishing gradually toward the right iliac fossa. The uterus and ovaries, by vaginal touch, were free from pain and swelling.

At the consultation it was decided to give her hypodermatics of morphia, with brandy and milk, and in the morning, if she was not better, to do an exploratory laparatomy.

June 28, 11 A. M. The pain continued as bad as before, with the extremities cold and pulse irregular—92 to the minute—respiration, 24; temperature, 97.4°. An exploratory laparatomy was done, the incision being at the border of the right rectus. The diagnosis had been that of appendicitis, or some indeterminate trouble with the liver or gall-bladder. The kidney did not seem to be tender. On opening the abdomen the lower border of the liver was seen, and was evidently somewhat reddened and fleshy-looking. This was bound to the colon by recent adhesions, and the peritoneum of the corresponding belly-wall was deeply injected. The gall-bladder was normal, and there was no evidence of trouble behind the colon (see "Remarks" below) or with

the kidney. No abscess or other cause for the inflammation could be detected. The right iliac region and caput coli showed no disease, but the appendix was not found. There was a considerable accumulation of serum in the right flank. The intestines were normal, also the uterus and the right ovary. In the left ovary was a small cyst. The abdomen was well flushed with warm water, and reluctantly closed after inserting a drainage-tube in the affected area. I felt assured that I had not discovered the reason for her dangerous illness.

4 P. M. She was much more comfortable than before the operation, and her extremities, though not warm, were much less cold.

29*th*. She passed a poor night, with constant bilious vomiting. Temperature, 97.4°; extremities again cold. We ordered one-quarter of a grain of cocaine every hour, and a full enema with glycerin, followed, if need be, by an enema of two drachms of sulphate magnesia every two hours.

6 P. M. Temperature, 98.2°; pulse, 92; respiration, 24. Has had four large stools, and feels much more comfortable. The belly is not nearly so tender. The vomiting ceased with the first dose of cocaine, and she feels hungry. A moderate amount of bloody serum had escaped by the tube, which was now removed. A considerable amount of apparently purulent, leucorrheal discharge had occurred during the day.

July 2. From the time of the last note she gradually sank, with symptoms of collapse, subnormal temperature, and constant vomiting, until she died, at 9 P. M., on the 30th.

The post-mortem, thirteen hours after death, disclosed the fact that her death was caused by a perforative appendicitis. The appendix was three inches long, and lay directly behind the cecum and colon, being agglutinated to them, with no peritoneal covering, but lying between the two layers of the meso-colon. Its tip was perforated. Less than two drachms of pus, mixed with a small amount of fecal matter, was found in the abscess. The wound itself and the peritoneal cavity were entirely aseptic.

REMARKS.

I record this case especially as a lesson in diagnosis and a warning in treatment. When first called to see it, the history, the collapse, the rigidity of the right side of the belly, and the flexure of the right leg, all betokened an appendicitis. And yet the right iliac fossa was free from tenderness, free from tumor, free from edema, free from pain. There was a slight pain and tenderness all over the right half of the belly, but the most painful spot was far away from McBurney's point, and was just under the border of the liver and about an inch inside the line of the anterior superior spine. The abdomen at this point, over an area of 2.5 to 3 inches,

was so exquisitely tender, that no satisfactory examination could be made. Although appendicitis was in my mind as a first thought, the position of the tenderness suggested probable rupture of the gall-bladder from gall-stones, or a renal calculus, as the probable cause. When the abdomen was opened, the localized patch of peritonitis was external to the attachments of the mesocolon, and showed no indication of any trouble back of the colon as its possible cause. In spite of this, however, I examined three several times, with the most minute care, the entire region of the colon, from the cecum to the hepatic flexure: first on its outer side, then on its inner side, and then by bi-manual examination from side to side, and by palpation from before backward, but could detect no hardness or other evidence of any abscess.

That no larger an amount of pus should have formed after an illness lasting eight days is very unusual, and while I deeply regret not having discovered the abscess, I cannot but console myself with the thought that it was not for the want of a careful and thorough search, but by reason of the unusual conditions and the small size of the abscess. Whether in the absence of all physical signs of such an abscess it would have been my duty to dissect up the colon in order to examine the recto-colic tissues and appendix, or to have torn through the outer layer of the mesocolon, is a question I have much debated. Viewing now the facts, I greatly regret not having done so, and I report the case especially as a guide and warning to other surgeons who may meet with similar cases.

THIRD PAPER.

THE OPERATIVE TREATMENT OF APPENDICITIS.

By THOMAS S. K. MORTON, M. D.

MR. PRESIDENT, LADIES AND GENTLEMEN: Since being requested by the directors a few days since to open the discussion of the Operative Treatment of Appendicitis, I have taken a glance through the literature of the subject, in order to offer, as it were, a consensus of opinion regarding the present status of the subject, as well as to draw conclusions from such personal experience as has fallen to my lot in this direction. Now I find myself embarrassed by the necessity of limiting my remarks to the few moments which are at my disposal, and to crowd into them even bare mention of the most salient facts. Hence, much must be entirely omitted and other points given scant attention.

The discussion being limited to operative treatment, pathology and diagnosis—perhaps the most interesting branches of the subject, even to surgeons—are not to be touched upon except incidentally. But I cannot refrain, in passing, from saying, that as the ratio of appendicular to cecal inflammatory affections is probably 100 to 1, hence that *differential* diagnosis in diseases of this region which is usually impossible prior to surgical interference, is neither necessary or important, as operative procedures up to the point of establishing diagnosis are identical for all affections of the cecal region. Again, I would condemn, without qualification, needle explorations as an aid to diagnosis. The procedure is inherently dangerous, and will furnish no indication that cannot otherwise be obtained.

The number of cases of appendicular disease discovered when we are upon the outlook for them, is astonishing. A large proportion of peritonitis cases in males, and especially in children, arise from this disorder; and in all cases presenting abdominal pain, whether acute, chronic, or recurring, no matter where referred, we should think of and examine for possible appendicitis. I have come to be very skeptical of such conditions as are described as abdominal "cramps," "colic," etc., particularly when of frequent recurrence. Curious as it may appear, yet it is a fact that the great majority of the profession are only now beginning to recognize cases of appendicitis and its consequences as such. Formerly the affection was almost universally diagnosticated as anything except itself. But just in proportion as the disease continues to be more certainly recognized, so surgeons are more early operating upon cases which demand interference, and, as a consequence, the mortality from the disease, as well as from the operation, is very rapidly on the decline.

Keen has said that "the first indication in appendicitis is to call a surgeon," that the physician, who almost invariably first sees the case, and the surgeon, may together watch the case, and if operation becomes necessary, interference may be prompt and well timed; while the surgeon will have the great advantage of being already familiar with the case, and not disposed to delay the operation that he may acquire such familiarity. Again, Mynter has well said that "we are utterly unable to judge correctly from symptoms alone of the extent and severity of appendix lesions, and for this reason alone abdominal section is and must be the safest method of treatment" in many cases.

When shall we operate? Judging from the cases that I have observed, and from the writings of others, I would formulate as a good working rule: To operate not later than the third day of disease, if the patient up to that time has failed to markedly improve under rest, restricted diet, purgation, and topical applications. Especially should this rule be adhered to in cases where we have failed to move the bowels—these are apt to be the fatal ones. Further than this, we should invariably operate as soon as the presence of pus is assured; when peritonitis is developing or spreading; when signs of sudden rupture of an abscess into the peritoneal cavity appear; and where septicemia from septic absorption is taking place. In children, operation must often be performed earlier than in adults, as with them the malady is more speedy in development, more fatal in tendency, and shows a greater proclivity to involve the general peritoneum.

But let me emphasize the point that *pain* is not a reliable symptom (especially when opiates have been administered) from which to judge as to whether the patient is better or worse; most weight should be given to the strength, temperature and condition of the bowels, stomach and general abdomen.

Mr. Treves urges that operation shall not be done until the fifth, sixth, or later day. But from my reading and experience I think this is too late. He argues thus, because few deaths occur before the fourth or sixth day. These cases, however, really begin to die the third, fourth, or fifth day, although death may not actually take place before the sixth or later day, when the possibility of benefit from operation has passed. If the case is progressing well and operation is being postponed, it should be watched and observed frequently and most carefully, for we cannot predict at what moment an appendix abscess may perforate into the peritoneum, or other dangerous complication arise, that will instantly demand operation.

If the case is operated upon early, the chances of recovery, as a rule, are exceedingly good. The mortality of appendicitis during the first forty-eight hours is almost *nil*, and the operative death-rate at that time is equally low. Later both rates increase, but the former much more rapidly than the latter. The patient, in this disease, is generally strong and well up to the moment of seizure, at which time the danger of operation *per se* is at the minimum. Such mortality as results in operations for appendicitis, has been mainly incident to undue delay. When physicians and surgeons

generally have learned definitely to recognize such cases as are operative at a time before the vital forces have been too much sapped or dangerous complications have arisen, then will the mortality rate of both disease and operation remain steadily at a low figure.

Then, again, the local conditions, from an operative standpoint, are much less serious in the early stages. We have at first simply a swollen appendix, with infiltration, and, perhaps, a few adhesions. We then do not have to deal with fetid abscess, foul surroundings, and sloughing tissues, which may have given rise to intestinal gangrene and other complications, as well as to the impossibility of securing primary union of the wound. Hernia is more common as a sequel in cases where the operation is performed late, and where the surroundings are gangrenous, and we can only secure healing by secondary intent.

The cry of every writer is for earlier operations. I have found no surgeon who regrets having operated early, but almost all mourn cases that were operated upon too late. No case appears where a mistake in diagnosis has been made, despite the awful array of affections which has been drawn up as liable to render uncertain the recognition of appendicitis. On the other hand, very many cases opened with the expectation of finding other disorders have proved to be appendicitis.

Who shall operate? The operation for appendicitis may prove to be the most easy; but it is never trivial, often trying, and sometimes even baffling the skill of the very best abdominal surgeons. Hence, he who undertakes operation for the removal of the appendix for disease should be equal to dealing with any of the complications and emergencies of abdominal surgery. There is scarcely a complication which occurs in abdominal disease, that may not be met with in operations on the appendix. If a man knows only how to reach the appendix, it is not enough; he must be able to cope with any accident or emergency that may arise. Therefore, he must have had training in general abdominal surgery.

How shall we operate? There are two classes of cases to be dealt with. One, the acute, where there is perhaps abscess, perforation, or general peritonitis; and, second, those where operation is undertaken in the interval between acute attacks, as a prophylactic measure. The indications for the latter will be considered separately further on.

The preparations for the operation are usually of a hurried

nature, on account of the active nature of the disease and the sudden determination that operation has become imperative. Previous purgation, if successful, will make the chances of recovery much more bright, no matter during what stage of the disease operation is performed. Cases where the bowels have been kept open from the outset of attack are always most favorable. Locally the abdomen should be cleansed as for any other operation.

All writers now agree that the incision should be lateral. Median incision is only permissible when diagnosis from other abdominal disease is not clearly made out, as where we have had suddenly developed, violent peritonitis arise without obvious cause. Even should the median incision have been made, and the affection prove to be appendicitis, especially if septic, a lateral incision should still be resorted to, for it is exceedingly difficult and dangerous to drain septic appendicitis cases through a median incision, and often it is impossible to deal with complications, or with the appendix itself, except by the more direct route. I am of the opinion that almost any complication arising from appendix or cecal disease, can best be dealt with through the lateral incision. No writer has regretted making the lateral incision, although many have regretted entering through the linea alba.

This incision should be about three or four inches in length, and terminate one inch and a half above Poupart's ligament. It should be carried down to its full extent through the right linea semilunaris until the peritoneum is reached, avoiding, if possible, the epigastric artery, which normally would be situated to the inner side of the lower extremity of the wound. I have seen serious secondary hemorrhage from division of this artery. Having reached the peritoneum, if one does not at once get into the abscess cavity, we must exercise great caution not to open the gut by mistake. Sometimes adhesions will be found binding intestine to the peritoneum in the line of incision, and in these cases it is well to go at once to the lower or upper extremity of the wound, get into the general peritoneal cavity, and work upward or downward, as the case may be, to the cecum, when all adhesions can be separated by the finger or knife, and the peritoneum opened to the full extent of the external incision. Of course, the incision should be increased in size if there is any difficulty in getting into the peritoneal cavity, or subsequently if difficulty arises in any manipulation from lack of working room. But, as a rule, the smaller the incision the better, because of the less risk of subsequent hernia. The head of the

colon is then sought out. If now it is found difficult to determine the site of the appendix, the longitudinal muscular bands of the colon may readily be followed down to their termination in the root of the appendix. Then by careful manipulation one can usually trace the appendix, even through a mass of dense adhesions, and dissect it out. As a rule, in acute cases the organ will be found more or less free in the cavity of an abscess, with its tip, perhaps, adherent to omentum or bowel. The appendix is to be dissected out with the finger, and often we do not see it until it is brought out of the wound ready to be ligated off. This manipulation closely corresponds to the modern one of removing the uterine appendages.

Now, what shall be done if the appendix is found to be bound down by a dense mass of adhesions, and if it would take a long dissection and endanger life from the time required to complete the operation? Under these circumstances I would advise that the appendix be left alone rather than run any great risk of the patient's life to complete an ideal operation. We are often compelled to operate to save life, and that alone, even if we do run the risk (as of leaving the appendix) of recurrence. I do not regard the operation as complete in any case unless the appendix is removed, and we should never hesitate to dissect out or remove the organ simply for fear of opening up the general peritoneal cavity.

Cases of recurrence, with great violence of symptoms, are upon record, where operation had been performed and the appendix not removed. Here, again, we have a parallel with the removal of the uterine appendages. Who considers that he has done a complete operation when he simply drains a pyosalpinx? Yet there is a small (but constantly decreasing) proportion of these cases that must be so treated rather than endanger life by prolonging operation, shock, and anesthesia.

If the appendix can be excised, the question arises as to how we shall deal with it after separating all adhesions. In septic cases it will be found usually impossible to invaginate the stump, after cutting away the appendix, into the cavity of the cecum and approximate peritoneum to the remaining opening. Where we operate between attacks, the appendix, as a rule, can be dealt with in this manner and the invaginated stump retained by a few Lembert sutures, approximating the surfaces of the cecum over the aperture. When, however, the organ and its surroundings are swollen and

gangrenous, the conditions are such that it is generally impossible to invaginate the stump. It has seemed quite sufficient in these septic cases to ligate the appendix a quarter of an inch from its root with strong silk, and then cut off both the appendix and the ligature ends. But ligatures will neither become absorbed or encapsuled where septic conditions are present, and I have seen the threads coming out of the wound months afterward from persistent sinus or by ulceration. So it occurred to me that we might resort to the old surgical procedure of leaving one end of the ligature hanging out of the wound. That experiment I am now trying in a recent case. Chronic ligature sinuses assist in the production of hernia by interfering with solid union.

Frequently the appendix will be found with a mes-appendix. This should be ligated *en masse* or in sections, and cut away from the appendix. Then the appendix is ligated at its base and removed. Removal of the appendix is almost universally recommended, but Mr. Treves has simply straightened an appendix which he found angulated by adhesions and left it in the wound. Mr. Tait has practised in more than one case splitting open the appendix and inserting a fine drain-tube into it. From these instances it will be seen that there exists in some minds an almost superstitious fear of removing the appendix. Certainly no sentiment can exist concerning the ablation of the appendix such as there is in regard to the ovaries and Fallopian tubes. Having the appendix once in hand, it does not add to the dangers of the operation in the least degree to remove it, while recurrence of the disease is thereby rendered impossible.

Occasionally the appendix is found to have sloughed off at its root, leaving a ragged opening into the cecum. In one or two cases the edges of the opening thus left have been inverted and closed successfully by Lembert sutures. In others the wound was left entirely open and packed with gauze; an intestinal fistula or artificial anus formed, but in time closed spontaneously. Yet another required a subsequent operation and Lembert sutures before it was cured.

Some surgeons recommend that in septic cases a little flap of peritoneum be sewed across the stump, or that it be tucked under a bit of omentum. I can see no advantage in this. It prolongs the operation and does no good, while by so doing we risk the formation of a secondary abscess pocket. Very many appendix stumps have been simply dropped into the wound again after

ligation; fecal fistula did not form, and the wound closed satisfactorily.

Any portions of gangrenous omentum presenting in the wound should also be ligated beyond the junction with healthy tissues and cut off. Any small openings into the peritoneal cavity may next be sewed up carefully if the general peritoneum does not require drainage.

Then in regard to irrigation: if the general peritoneal cavity has been opened extensively, or if it is septic, it should be thoroughly washed out through the lateral incision. If it has not been involved, the abscess cavity and wound alone should be irrigated. Under the latter circumstance we may employ a strong bichloride solution, but if the peritoneum is to be flushed, nothing but water should be used.

If the general peritoneum has been septic or extensively opened or manipulated, it is essential to use drain-tubes to the base of the pelvis. The ordinary straight glass tubes do not answer well, and rubber is not satisfactory. Here I have a collection of angulated and curved glass tubes, most of which have been used with great satisfaction in appendix cases. The angle makes it possible to get the tube to fit well over the brim of the pelvis, yet not to project awkwardly from the lateral wound. By attaching a few inches of rubber tubing to the end of the ordinary cleansing syringe, the bent tube can readily be cleaned.

The suturing of the wound is especially important if the case is *not* a septic one. Then the tissues should be sutured layer by layer; this gives the best assurance of firm primary union and the avoidance of hernia. If, however, the wound is septic, and drainage or packing is employed, secondary union is inevitable. But I would still urge that the wound be as carefully sutured as possible in all cases, leaving ample room for exit of the drain-tube or packing. And I might say, in passing, that simple packing with strips of double cyanide or iodoform gauze will be found to answer all purposes of drainage in cases where the general peritoneum does not also require drainage.

Some surgeons advise using no stitching in septic cases, but simply packing of the entire wound with gauze. But by suturing we can usually secure primary union in a portion of even a foul wound, and temporary stitching has appeared to give a certain anchorage and support to the subjacent intestines, which, when the sutures are removed, is more or less retained. The stitches, of

course, are to be removed, one or more at a time, when swelling, infiltration, tension, or deficient drainage, becomes apparent. Strips of adhesive plaster should be employed to give the wound support and approximation during granulation.

Complications such as gangrene of intestine or mesentery, must be dealt with upon general principles of abdominal surgery. If intestinal obstruction complicates the case, the site of obstruction should be ascertained, and the condition relieved, if possible, before closing the wound. Cases in which obstinate constipation has existed up to the time of operation, should be examined during its performance for possible obstruction.

Should peritonitis develop subsequent to operation, and not speedily yield to active purgation, the wound must be reopened, and the abdominal cavity irrigated thoroughly and drained. Continued obstruction could probably be best dealt with through a new median incision rather than through the original wound.

As soon as the patient comes out of ether, if the bowels have not been well emptied before operation, it is my custom to at once begin the administration of one-eighth grain doses each of calomel and podophyllin, at twenty-minute intervals, until purgation is accomplished. This usually takes but very few hours. Later, salines may be employed if required.

Full strength peroxide of hydrogen solution has given me great satisfaction for cleansing and washing the wound cavity when suppuration commences and sloughs are forming—it greatly facilitates the separation of the latter.

Persisting fecal fistula usually close spontaneously in time. Should they not, then reopening of the parts several months later, and suturing of the cecal or other opening with Lembert's sutures, is indicated, and has proved successful in several instances.

In conclusion, let me say a word in regard to operations undertaken in the interval between acute attacks, or what may be termed *prophylactic operative treatment.*

The indications for this measure are: Constantly recurring attacks (usually indicative of the presence of a foreign body in the appendix), which interfere with the individual gaining a livelihood, or render his life a constant burden, worry, and expense to him; also, where recurrent attacks have taken place in those, as seamen, hunters, explorers, etc., who are liable to be again attacked when they may be out of reach of adequate surgical aid. In this class of patients, operation during quiescence of the disease should be

considered, and, perhaps, urged by the medical attendant. In most other cases, I do not think excision of the appendix should be often attempted in the quiescent period. We should rather counsel delay until the onset of the next acute seizure, when we can conscientiously urge the removal of the offending organ at once—that is, on the first or second day. This advice is given principally because of the great difficulties and dangers frequently encountered in operating during the intervals of attack when the adhesions are extremely dense. In fact, patients have died as a result of the long time required to complete the operation, because of the elaborate dissection required to free the appendix from its matrix of densely organized adhesions. In several instances the very best operators have been compelled to abandon these operations in the intervals of attacks, not only without having been able to remove the appendix, but also without having been able to discover the organ in its bed of adhesions.

DISCUSSION.

Dr. WILLIAM PEPPER: I scarcely think that I need say much, for the subject as presented is so largely one of operative technique, that the views of a purely medical clinician possibly are scarcely appropriate. Assuming that the subject under discussion includes all the acute inflammatory affections of the appendix, cecum, and pericecal tissues, much has been said to which I should take strong exception from the standpoint of a pure medical practitioner. I believe that if every case of appendicitis were operated on, the mortality would be ten-fold what it now is. For more than a quarter of a century I have been in the habit of seeing a great many cases of appendicitis every year. I base this statement partly upon the classical researches of Dr. Fitz, who has demonstrated more clearly than any other, that in a large proportion of cases of right iliac trouble the appendix shares in the disease, if, indeed, it is not the starting-point of the malady. Now, as a general rule, these cases recover under medical treatment, and remain permanently well afterward, no surgeon being associated in the treatment of the case. In no year during the past two decades have I failed to see a considerable number of cases of this kind, and the cases that have demanded operation, as contrasted with those which get perfectly well without operation, is probably at least as one to a score. I think the assertion that as soon as appendicitis is suspected the surgeon should be called in, is quite out of accord with the experience of physicians the world over. As I have said,

I think that the vast majority of cases, in first attacks at least, undergo resolution and terminate with some more or less permanent injury to the appendix, but without going on to the production of abscess, provided the treatment be instituted early and be kept up faithfully. In many of these cases there is early development of induration and fulness in the right iliac fossa, and in proportion as this appears early, is it likely that the case will run a favorable course, or, if later it develops signs of suppuration, it will admit of treatment by the simple Willard Parker extra-peritoneal incision. In proportion as the symptoms are violent, without localizing phenomena in the right iliac fossa: is there danger that rupture of an abscess has occurred, to be followed by the development of general peritonitis. I am entirely at one with the speakers who insist on early operation where this latter condition exists. I have had the operation performed as early as thirty-six hours from the initial symptom, and have found suppurative peritonitis already present. m sorry to say that in this case there was a fatal result, as will sometimes happen in the hands of the most skilful operator. I think that the experience of all will confirm the statement that the operation is a grave one. The operation of laparatomy for disease of the appendix, whether it is exploratory or radicle, is not a trifling operation, and I have rather extensive records to show that it is an operation attended with a great deal of danger, even in the hands of the most brilliant operator. I should protest against the view that, as soon as the diganosis of appendicitis is made, an operation should be encouraged.

I believe that it is possible to note the time in a certain large proportion of such cases, when the symptoms indicate the spread of inflammation, and then I think that the operation cannot be too promptly performed.

The question of diagnosis remains, in spite of all the good work that has been done, a most difficult question. The McBurney point I believe to be largely without value, uncertain in its location on account of the very varying relations of the appendix, apt to be mistaken for points of tenderness due to wholly different causes, and apt possibly to be mistaken for sympathetic tenderness of nerve points in the abdominal wall. I, therefore, believe that this sign, from which much was hoped, will prove to have very little positive diagnostic value.

The rectal examination has seemed to me to be of very material value; it is true not so early as we could wish, but in many

operative cases I have found the roof of the pelvis altered as determined by a careful rectal exploration. I feel that I am wholly incapable of putting in words, nor do I know that this has been done, the exact differential diagnosis of the cases which demand early operation. While this is true, I would still urge the view that this does not justify the subjection of every patient with appendicitis to laparatomy. I trust that we shall learn to arrive at a more exact differential diagnosis. There is a combination of a certain history of the development of the case, which, taken in connection with the facies, the general symptoms, and the abdominal condition, as determined by external and by rectal examination, will, in the hands of an experienced clinician, serve in the great majority of cases as a basis for this diagnosis. It is difficult to state this in terms as precise as we should state the terms of a diagnosis of encysted pleurisy, but I think that those who have studied these cases will recognize a *tout ensemble* which admits of a diagnosis of those cases which should be subjected to early operation. I believe, on the other hand, that in the great majority of cases we are justified either by the mildness of the symptoms or the localizing tendency in the right iliac fossa in urging medical treatment, and this is further justified by the very frequent recovery of these cases.

Lastly, I shall say a word as to my entire opposition to operation in the majority of cases in the interval between recurring attacks. I think that medical records will show too many cases where thorough treatment, hygienic, dietetic, and medical, has been followed by complete cure. I have had so many such cases in which cure has occurred after a number of recurrent attacks, that the adoption of a general rule that where a patient has had two, three, or more attacks, he should be subjected to a grave operation like laparatomy, seems to be a dangerous postulate. I think it better to secure the consent of the patient to the performance of the operation, should alarming symptoms make their appearance in any attack, and then to persevere with carefully regulated medical treatment. There are cases, unquestionably, where the conditions of the patient, the fact that he may be attacked when out of reach of skilful surgical aid, make it necessary for the patient to decide between a change in his habits of life and an operation. These are exceptions, and it does not follow that a general rule that laparatomy should be performed in the interval between recurrent attacks of appendicitis, should be laid down.

Dr. KEEN : I wish to take exception to what Dr. Pepper has said in reference to not calling in a surgeon in a case of appendicitis until operation is needed. I think that it is of the most urgent importance that the surgeon be called in not to do an operation, but for consultation, for his judgment rather than his knife — not necessarily to do a, laparatomy immediately — but for the purpose of being ready to deal intelligently and promptly with the conditions when the time for operation arrives. He should not be called in then, new to the case and unfamiliar with its features, and desiring, therefore, time to become familiar with it, unless the case is so serious that operation is evidently and instantly required. The surgeon should be with the physician the moment the diagnosis is made, not to do the operation then, but to be ready to do it the moment that it becomes necessary. I have seen cases lost, and have lost some myself, I am sure, from delay, from the natural unwillingness to plunge right in and do a laparatomy the moment we are called to see a case that really needs it, and yet from unfamiliarity is regarded as a doubtful case. We should have every point at our fingers' end and be familiar with the fluctuations of the symptoms. Then our aid will be much more valuable than if we are called in only when the emergency for operation has arisen. A plain case every one can read and decide quickly. It is the doubtful cases that need carefully weighed decision — a snap judgment on a sudden call is more apt to be wrong than right.

Mr. THOMAS BRYANT, of London (by invitation) : I assume that the term appendicitis as here used includes all those cases which have been spoken of as typhlitis, pertyphlitis, and by other names, all of which have probably more or less connection with the appendix itself. Starting with that assumption, I at once proceed to the treatment of appendicitis. Here at the beginning, although a surgeon, I agree very strongly with the observations of Dr. Pepper. I am convinced that operative treatment is most valuable in appendicitis. I am equally convinced that delay in operating is the wisest course in the majority of cases. I should like to say in this place it seems to me that the authors are a little mixed in regard to the classification of these cases. They have included cases that are acute from the beginning, with cases that are not acute, that have a slow and steady course. The cases that have a slow and steady progress, that begin with localized pain is the right iliac fossa, accompanied with tenderness and soreness, less swelling without any very acute symptoms, are cases which you must feel can be dealt with satis-

factorily without the surgeon's knife; I do not say without the surgeon's aid, but without the surgeon's knife.

Dr. Morton spoke strongly of the use in these cases of calomel and podophylin. Such statements rather startled me and I should have been glad to have had some evidence of its value given. I should prefer to follow the line of treatment suggested by Dr. Pepper and not give calomel and podophylin in frequently repeated doses. I would rely more upon rest, belladonna externally and opium internally, and diet, believing that by such means the bulk of the cases are permanently cured. In exceptional cases where these good results do not occur and graver symptoms appear, the swelling increases and symptoms of peritonitis develop, the surgeon's aid becomes of immense value, and certainly where these symptoms do appear and there is a steady progression toward the bad, it is, unquestionably, time for the surgeon to take a hand. In all acute cases I have no doubt as to the right of the surgeon to interfere. I have seen cases where within thirty-six hours after such acute symptoms it was necessary for the surgeon to expose the part and let out the inflammatory fluids, if not remove the appendix itself. To my mind these two classes of cases, which I have briefly described, fairly indicate the line that the surgeon should take: trusting very much to expectant treatment in the least acute cases, and surgically interfering early in the acute.

In reply to the question in regard to the propriety of operating, whether or not the surgeon is justified in operating between the attacks, my judgment would decide in the negative. In the majority of cases there is no second attack. If there is a second attack, it can be treated on the same lines as the first, only there is a tendency toward interference if the symptoms do not settle down rather rapidly. I say this because I am sure that I have seen many instances where things have settled down after a second attack without any further trouble. Because we have met with cases that after the second, third, fourth, or it may be the eighteenth attack, have at last come to the surgeon's knife, I think that we should not accept that as a decided evidence in favor of surgical interference. In fact, we must be governed by each case itself, and we should surgically interfere only when we find small chances of Nature terminating the case guided by medical skill.

Now we come to the operation. I am not sure that I am quite in accord with the authors of the papers. It is quite true that in doubtful cases of appendicitis — that is, cases in which you do not

expect to find a great deal of pus or inflammatory fluid, the incision in the right semilunar line will probably be the best. In this way you come down readily on the cecum, and you are more apt to find the appendix. The majority of cases with which the surgeon has to deal are not quite in the stage to which I have referred. There is generally much more diffused swelling about the cecum, and that swelling gravitates backward and upward, sometimes toward the loin. I can recall a good many cases that I have opened where I was certain the swelling was about the cecum, but it was found backward toward the lumbar region. I can recall several instances in which my attention was drawn more to the lumbar region than to any other part, and it was only by going into the history that I concluded that the trouble was located in the cecum. The lateral incision is a good one in these cases, but it must be more lateral than the semilunar line. I have made my incision well back, corresponding to the line of the anterior superior spinous process and tending backward toward the loin. In this way you get well at the cecum and your finger can be readily passed into the iliac fossa. You can examine the part, you can drain the part well, and generally by the open treatment, not being too careful to stitch the wound, a good result takes place. I would say that in a large number of cases—my friends may say neglected cases—that an incision more posterior than the semilunar line would be the better one. The incision in the semilunar line should be reserved for cases that have not advanced to such an extent as I have just indicated. If there were time, I could give the Society many cases as illustrations of the truth of what I have said.

Another point to which I should like to allude, is the question whether or not these are all really cases of appendicitis. In at least three instances of cases which had presented a history of a cecal trouble, but in which death had resulted from some other cause, I have found cicatrices in the posterior part of the cecum, some distance from the appendix. In two cases that I have treated, the evidence pointed to the cecum as the seat of trouble. In one, a boy aged twelve years, I incised an abscess, and eventually a large orange seed escaped. I have no reason to believe that that could have come from the appendix. In the second case, a piece of bone, that had been swallowed, had evidently passed through the wall of the cecum and caused suppuration. These two cases presented all the features of typical appendicitis. They were dealt with in the way that I have stated, and both recovered. We must, I think,

bear in mind that these cases are not all due to disease of the appendix, and that many of these may have no connection with it.

This brings me to another point, and that is, whether or not, under all circumstances, it is expedient to search very carefully for the appendix.

In these severe cases should we disturb the parts so much as is often absolutely necessary? We have had, tonight, good evidence of the difficulty of finding the appendix in some cases. I have always felt that in these cases we should do more harm than good if we searched too far for the appendix. I am satisfied with well irrigating the part and treating it by the open method.

Dr. Morton has mentioned hernia as following the operation. I have never seen this. That may be because the bulk of my incisions have been made posteriorly. I have done many of these operations, and have seen many others done by my friends, but I have never seen hernia as a result.

Dr. J. M. BALDY: It has always seemed to me that it was not so much a question of the diagnosis of appendicitis, as the differentiation between the operative and the non-operative cases. The diagnosis of appendicitis *per se* is extremely easy; at least, so I have found it. As far as symptoms are concerned, I know of only one that is of fixed value, and that is, constant, deep-seated pain in the right iliac fossa, with induration. I think in such a case there is little question but that there is inflammation in or about the head of the cecum, and, presumably in the majority of cases, in the appendix.

Mr. Bryant has spoken of cases where large foreign bodies have been discharged through an abscess, and claims they have come from the cecum. He offers no evidence of this, except the size of the body. I have seen the appendix sloughed off, leaving a sufficient opening in the cecum to admit the index finger, so that I cannot see that the size of the body indicates in any way that it came from the cecum, and not from the appendix.

I have been glad, and, at the same time, rather surprised to hear the McBurney point condemned. I believe that it is utterly worthless as a reliable point in the diagnosis. It is one of those attempts at refinement in diagnosis which are apt to lead only too many astray. I have tried to apply McBurney's point, but have failed in every case.

The rectal examination may be of value in many cases, but we have all seen cases— and Dr. Keen's is one in point—in which there

is a small abscess high up, which could by no possibility be recognized by rectal examination. If the abscess contains many ounces of pus, it will generally extend downward to the pelvis, and may be felt through the rectum. There are, however, so many cases in which this cannot be done, that we can place no definite value on this method except in a limited number of cases.

I cannot help thinking that purgation is of distinct value when I see the great relief afforded to a man groaning with the most intense pain, simply from having a movement of his bowels. It may not be curative, but in every case, whether abscess is present or not, it gives great relief. I believe that purgation should always be used. At the same time, if the patient was suffering, I should not hesitate to use opium until the purgation had acted, or after it had acted in case of necessity. The amount required is not great, and will not interfere with the purgation. Those cases in which it is difficult or impossible to induce purgation, are going to do badly.

I know of no other intra-abdominal disease in which it requires more skill and practical experience to differentiate between those cases that should be let alone surgically, and those which should be operated on. I grant that the majority of cases of appendicitis get well without any operation. Again, there are certain cases that do badly from the beginning, and in which operation is clearly indicated. But, with certainty, there remains that large class of border-line cases, in which it is next to impossible to say whether pus is present or not. If there *is* pus, no one should hesitate. The operation for abscess is simple and easy. The abscess once opened, I do not think that in these acute cases any time should be lost in searching for the appendix. In trying to find the appendix, and even when found, in trying to remove it, the general peritoneal cavity will often be opened, and life will be lost where otherwise it would have been saved. Only one case, as far as I am aware, has been reported in which the abscess has been opened, and the appendix left, where a second operation was required for a severe recurrent attack.

I believe with Dr. Keen that the surgeon should be associated with the case from the beginning, although not necessarily to operate. When a physician is called in to operate, the tendency, if there is doubt—and doubt only too often exists—is to postpone the operation. If the surgeon has seen the case from the beginning, and studied the symptoms and knows the details, when the time comes he will have made up his mind whether or not to oper-

ate. If, however, the surgeon loses another twelve or twenty-four hours in hesitation, in addition to what the physician has already wasted, the patient may be irretrievably lost. The deaths after operation are due not so much to operation as to delay.

It is impossible to lay down any rule as to the time at which operation should be performed in any case, or in any class of cases. In some, the onset is so sudden and violent that it is impossible to come to any decision as to the seat of disease. This was the case in the patient reported by Dr. Keen, and in another instance I know of in New Jersey. In the latter case, it was not until a few hours before death that the symptoms were sufficiently marked to cause any alarm. This is often the history of cases in which the operation is postponed. The patient will be doing well until within a few hours of death, when the end comes suddenly, and the patient sinks rapidly.

Dr. FRANK WOODBURY: Although as a physician I look at this subject from the medical standpoint, I am in favor of operating. To save time, I may say that I heartily coincide in the statements just made by Dr. Pepper. I also endorse the remarks of Mr. Bryant, in which he anticipated what I had intended to say —that is, that each case must be studied by itself. I think that the surgeon and physician look at these cases a little differently. The surgeon is looking for general rules to govern him in the treatment of cases, while the medical man is more in the habit of individualizing his patients. Concerning the propriety of operation and the results to be anticipated therefrom, we all acknowledge that there is in some individuals a tolerance to operative interference and to suppuration that does not exist in others. Some will survive dangerous gunshot wounds; others will perish from a slight injury. There are probably points that will enable us to determine this difference in tolerance of different individuals, and, were they in our possession, should undoubtedly enter into the question of operation, but at the present time, unfortunately, we are not prepared to formulate these points in any given case of appendicitis which comes before us. Physicians who are accustomed to go into the history of the patient and to investigate the antecedents of the case, know that individuals who belong to families with a high physical standard, and who lead regular lives, are able to stand severe illnesses and operations, coming through them speedily and well, while others; having poor family history, bear very little surgical interference, and easily succumb to disease.

The question of the time of operation and propriety of operation really resolves itself into the query, "At what time does a case of appendicitis become a surgical case?" I would here raise my voice against the physician yielding to the temptation to put a hypodermic needle into an iliac abscess or swelling in order to make the diagnosis. As soon as he does that, he takes surgical responsibilities on his shoulders, and in no case are they likely to be more serious than in appendicitis. The physician should have sufficient surgical knowledge to determine when the time for operation has arrived, or, acknowledging his inability to decide this, he should secure the best obtainable surgical advice, not necessarily to operate, however, but to determine the propriety and proper time for operation, if found necessary.

Among the cases that come to my mind, three stand forth prominently. One was the first case which I saw, some eighteen years ago. A man in the lower walks of life continued at his work as a machinist, making no complaint, until one day he fell on the floor of the shop in a collapse, and was brought to the Pennsylvania Hospital. He had a feeble pulse, and a hippocratic face; the surface was cold, and, as he was dying, no attempt was made at diagnosis. He died in a few hours, and a post-mortem showed it to be a case of perforative appendicitis, with perforation and the usual foreign body. Here there was no question of operation. The patient did not seek medical advice, and there was no time for operation.

The last case I saw in my own practice occurred last Spring, in a patient whom I had attended at intervals for a number of years. I had attended him a year before with a light attack of appendicitis, and warned him that if he had a subsequent attack he should consider the question of operation. He did have a subsequent attack while away from the city, and on his return was attended by another physician for three months. The man improved and was about, but always felt a weight and pain in the right iliac fossa. He was then taken with acute obstruction of the bowels with intense pain, and finally I was sent for. In this case nothing that was given him produced a movement of the bowels. I may say that in this case Dr. Thomas G. Morton operated on the second day after I saw him, but the patient died five days later without a movement of the bowels. The bowels were probably matted together and gangrenous.

The third case that occurred to me is one operated on also by

Dr. Thomas G. Morton five years ago, which I have reported to the College of Physicians[1] and to this Society. I believe that Dr. Morton claims that this was the first case in this country where the correct diagnosis was made prior to operation of amputation of the appendix, and where the patient recovered. The patient has been well since the operation, although prior to it he had had a number of attacks. The patient is present tonight, and I should be pleased to show him to the Society. He is still wearing a light truss to protect a weak place in the abdominal wall at the lower portion of the incision. [The patient was exhibited.]

Dr. H. A. Hare: I rise for information rather than to discuss the surgical aspect of the papers which we have heard. Like Mr. Bryant, I am at a loss to know why calomel and podophyllin, the latter in such large amounts as one-eighth of a grain every twenty minutes, should be given after an operation for appendicitis. Podophyllin is the slowest acting purge in the Pharmacopeia, taking eight or twelve hours to produce an effect, as a rule; not only this, but these drugs act on the small bowel, high up, while the appendix is in the large bowel, low down. If saline purgatives were ordered, it seems to be a better treatment, for we have evidence of their great value. Even these are not without danger. I do not believe that a man can take one-eighth grain of resin of podophyllin every twenty minutes until he is purged without producing much intestinal griping and pain. Anstie pointed out the fact that podophyllin was a distinct irritant, particularly to the small intestine.

Dr. De Forest Willard: Mr. Bryant has said that he has not seen hernia follow this operation. A boy came into my office today on whom I operated two years ago. He did perfectly well for a year, when, on attempting to lift a heavy body, the bowel protruded through the center of the cicatrix. He had worn a bandage and a truss, but I put on a heavier truss, which relieved him for a time. He returned in four months; the pressure of the truss had produced a large slough, and he came near having a perforation of the bowel. The ulcer finally healed. He now has at the outer angle of the wound a second small hernia, and at the inner angle there is a slight tendency to protrusion. The wound was a large one. The boy was in extremis at the time of operation, and there was an enormous accumulation of pus.

In regard to deep-seated pain and induration in the iliac fossa

1. Case reported in Proceedings of the College of Physicians of Philadelphia, vol. vii.

as a diagnostic sign, I have seen cases in whom there was not a particle of local pain or of induration.

The boy already mentioned had no such symptoms. He had been kicked at the umbilicus, and the pain was chiefly at that point, yet the abscess was in the iliac region. The appendix was open, and a small mass of feces had escaped. There was an enormous accumulation of pus extending down into the pelvis on one side. The appendix was removed, and the opening stitched.

DR. M. F. KIRKBRIDE: In the past year and a half I have had four cases, but shall speak only of one. I shall first refer to the history of the case as given in a letter to the previous attendant. The physician was called on Thursday, April 3d. The patient had been constipated for one day. It was at first thought that the case was one of typhoid fever, as the father had recently recovered from this disease. Calomel was given, but no action secured. Citrate of magnesia was given with the same result. The pain and tenderness in the right iliac region increased. There were some tympanites. Injections of soap and water with a few drops of turpentine were practised with no result. Salts in one-drachm doses were then given without effect. Vomiting began. It became apparent that it was a case of appendicitis with obstruction of the bowels. Injections given on Saturday morning were not retained. On Saturday a surgeon was called in consultation. Operation was decided on, but as the surroundings were not suitable the family was advised to have the patient admitted to a hospital. This they agreed to do, but at 3 P. M. decided not to do so. The physician in charge then declined to have anything more to do with the case.

I was called to see the patient on Sunday evening, at ten o'clock. The temperature was 99.5°, the respiration, 36. No pulse at the wrist. The heart-beats, 130. He vomited everything, and for several days had had stercoraceous vomiting. I gave hypodermics of morphine and atropine, and afterward hypodermics of strychnine. After he had re-acted somewhat, I put him in the knee-chest posture, and gave an enema of sulphate of magnesia, turpentine, glycerine, and warm water, and gave whiskey and turpentine by the mouth. I also gave for several hours sulphate of magnesia in one-drachm doses. The first two doses were rejected, but afterward there was no vomiting whatever. In three hours I had the tumor removed and the boy sleeping comfortably, and after that he got along nicely. On the sixth day after I was called, a slough passed from the bowel. This was three inches in diameter. The case then

went through that of a regular case of typhoid fever, as far as the temperature was concerned, and even showed the eruption. The diagnosis of appendicitis was made by two physicians and an eminent young surgeon.

Dr. Joseph Hoffman: McBurney's point has been condemned, but the reasons have not been given. The position of the appendix varies. You cannot lay your finger on any special point and say that there the appendix should be found. We must remember that the appendix revolves in three planes, and that, therefore, it may have three systems of revolution. We cannot expect to find the appendix always in the same position. This anatomical fact forever blots out McBurney's point.

In reference to purgation, I had a case, of which I shall not recite the points, in which the use of calomel and opium turned out beautifully, so far as the apparent curative effects are concerned. Dr. Wheeler was treating a case of appendicitis with opium for some days without benefit. He then called me in and I brought Dr. Price. He was then purged with calomel after the opium treatment, and the pain entirely disappeared. Shortly afterward he went to Baltimore and had a recurrent attack, from which he died. This shows what purgation will do.

Dr. M. Price: We are certainly slightly mixed in the discussion of this question. The physicians are talking about appendicitis without perforation, and the surgeons about appendicitis with perforation—conditions entirely opposite. Drs. Pepper and Meigs say they never saw but one single case of perforative appendicitis get well, and they reported that case themselves. It is true that this statement was reported fifteen years ago, but that does not make the disease any milder.

There is one other point. It is absolute folly to operate for appendicitis and expect good results, unless you can purge the patient. If you succeed, and after the operation persist in the use of purgatives, every case, so far as I know, will recover.

If at the operation there is found a barrier separating the abscess from the general peritoneal cavity, thorough irrigation of the abscess cavity is required. If this barrier cannot be demonstrated, thorough irrigation of the whole peritoneal cavity should be insisted upon. In a case operated on five weeks ago, there was well-marked thickening and induration in the right iliac fossa. I removed five or six ounces of pus, and when I came to irrigate, although I used every precaution, I found the small intestine slipping by my finger.

I washed the abdominal cavity out thoroughly, and passed in a straight glass drainage-tube, held in position by one stitch at the lower angle of the wound, and then packed with gauze down to the knuckle of intestine. The appendix was eaten off by an ulcer, and so gangrenous that I was afraid to touch it. The man was purged every day for a week, and made an uninterrupted recovery. I may mention that I have never seen a case of appendicitis with perforation and general peritoneal inflammation without a subnormal temperature.

DR. MORTON: There are many symptoms that have not been mentioned. Bladder irritation is a prominent symptom in some cases from inflammation or pressure on the ureter, or of the bladder wall. This brings out one of the dangers in operating on the appendix. Mr. Treves has predicted that some day a portion of the ureter will be taken out in mistake for the appendix or torn out with it.

It is also to be remembered that in perityphlitis the superficial veins are more engorged on the right side of the body than on the left.

Perhaps my views in regard to the time of operation have been misunderstood. What I desired to say was that no case that is not improving should be permitted to go beyond the third day without surgical interference. I do not mean to say that all cases should be left so long. In some the operation will be required in the first few hours; in others on the first day, and still others on the second day. The great majority of cases will recover from the present attack at least upon purgation, topical applications, and regulation of diet.

Another danger of allowing septic processes to go on in the neighborhood of the appendix is the development of phlebitis in the branches of the mesenteric vein causing troubles in the liver. Pain in the liver is often a sign of appendix disease. It has been held that many cases of abscess of the liver have originated in septic processes around the appendix infecting the veins. I saw Dr. Steinbach operate on a case in which the patient before operation showed a tinge of jaundice. The appendix ran upward nearly to the liver, and surrounded by a large abscess. Intense jaundice supervened after the operation, and the man died apparently from acute inflammatory degeneration of the liver. I believe that the liver trouble was a septic complication from the appendix.

In regard to the use of calomel and podophyllin, I would say

that I know very little about experimental therapeutics, but after giving the various purgatives a thorough trial I have found that minute doses of calomel and podophyllin, frequently repeated, give the best results in these cases. They move the bowels thoroughly and with rapidity. In the case reported, from fifteen to twenty movements were secured in eight or ten hours. These small doses cannot be vomited as readily as a drachm of salts can be, nor do they produce emesis even shortly after etherization, when salines would not be tolerated by the stomach. After the bowels have been thus started and the stomach quieted as a consequence, salts will be retained, if indicated, and work with greater promptitude and efficiency.

DR. PRICE (closing the discussion): I rejoice that in America we have adopted some of Mr. Bryant's surgical wisdom in regard to appendicitis, as well as in regard to hernia. "If you find a man hanging, cut him down."

I will allude to three cases in which there were recurring attacks. In one, the man had had twelve to fourteen attacks. I saw him in the last in collapse on the eighth, tenth, or perhaps the twelfth day. In this case the argument offered by the family physician was the common one: that as the patient had recovered from so many attacks he would also recover from this. This is a dangerous argument and often a fatal one. I said that this man would be dead in three hours; he died in an hour and a half. In a recent case I saw the patient on Monday. Dr. Agnew saw him on the same day, and we both urged section. The physician and family decided to wait. On the following Friday, Dr. Agnew was asked to operate and refused. Many of us are now taking high ground and refusing to operate at the eleventh hour. It is not fair to surgery to operate on dying patients. Dr. Agnew has recently operated in the twenty-fifth attack, removing a huge appendix, and the boy recovered.

Deaths from appendicitis are very numerous; indeed, more so than a year ago. They were then called typhoid fever, but now our methods of diagnosis are more accurate.

Mr. Tait's recommendation of drainage has been referred to. That would be as bad surgery as to drain a huge pus tube. The cheesy, disorganized appendage remains. No one would cut down on a sequestrum in bone disease and simply put in a drainage-tube.

I have the records of two cases of appendicitis, in one of which the opening was through the lungs and the other through the

esophagus. Dr. Hunter McGuire has reported a case in which the appendix was found floating in a puddle of pus. You will all remember the illustration in the *British Medical Journal* or the *Lancet* of a year ago, of a case of hepatic abscess with a large opening through the loin. You could see the liver, the kidney, and the colon. The man lived twelve days and died of dysentery. I never see a case of neglected appendicitis without thinking of this case of neglected abscess of the liver. In most cases that we see, the small intestines are enormously distended, and the pelvis is filled with adherent knuckles of bowels. In these you often have obstruction. In many cases the use of a purgative is simply folly before the adherent knuckles of intestine have been released by operation.

I scarcely favor the long-ligature method. In these cases I have inverted the stumps, and the transfixation has been made with the finest needles. If the appendix sloughs, it goes inside.

The McBurney point is wholly ununiform and worthless.

PARAFFINE IN DIPHTHERIA.—Mr. A. M. Sydney-Turner, Surgeon to the Gloucester County Infirmary, informs the *Lancet*, in reply to inquiries, that he has treated thirty cases of diphtheria (children and adults) with paraffine, and has had the satisfaction of seeing every one recover. His plan is to ask for the ordinary paraffine used in lamps, and having scraped off the diphtheritic patch, to apply the paraffine every hour to the throat (internally) with a large camel's hair brush. As a rule, the throat gets well in from twenty-four to forty-eight hours, and with improvement in the throat the paraffine is applied less frequently, but he continues to use it for two or three days after the complete disappearance of the patches. He speaks definitely as to the therapeutic effects, but is unable to state what the chemical action of paraffine on the diphtheritic membrane is; probably the hydrocarbons in the liquid exert some powerful influence on the membrane.—*Scientific American.*

MUSIC AND THERAPEUTICS.—It has lately been suggested that music might prove a useful adjunct (in some cases at least) where the usual routine treatment has not been satisfactory. We venture to suggest the following airs as being suitable for the cases enumerated, viz.: Retarded labor from inertia, "Comin' Thro' the Rye;" cases of chronic deafness, "Come back to Erin;" epilepsy. "Let Me Like a Soldier Fall;" pyrexia, "The Coolin';" melancholia, "The Heart Bowed Down;" cases of doubtful diagnosis, "Oh, Dear! What Can the Matter be?"—*Medical Press.*

BUFFALO MEDICAL AND SURGICAL JOURNAL

A MONTHLY REVIEW OF MEDICINE AND SURGERY.

EDITORS:

THOMAS LOTHROP, M. D. - - WM. WARREN POTTER, M. D.

All communications, whether of a literary or business character, should be addressed to the managing editor: 284 FRANKLIN STREET, BUFFALO, N. Y.

VOL. XXXI. DECEMBER, 1891. No. 5.

THE SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION.

THE fourth annual meeting of this renowned association was held in Richmond, Va., November 10, 11, and 12, 1891, and the deeds that it there accomplished have already passed into history. There are some features of medical associations that are proper subjects for discussion in the medical journals, and it is one of the provinces of the journalist to advise his readers as to the value of the several medical organizations and the quality of the work they do, while the meetings are still fresh in his mind. It is a pleasure to speak of such a gathering as convened at Richmond last month, because it was composed of some of the most eminent surgeons and gynecologists in the country, and, because further, that the scientific work accomplished was second to that of no special medical organization in the United States.

In the first place, everything conspired to make this meeting one of unusual success; its president was a man gifted in his profession and experienced in affairs; its secretary was indefatigable, energetic, and capable; the chairman of the committee of arrangements was one of the most eminent men that the South has ever produced; the time and place of meeting were the happiest possible — the capital of the Old Dominion, and the season was the loveliest of all the year, the charming Indian summer, that makes Richmond and its environs one of the most delightful spots on the continent. Finally, the weather, that has been charged with failure so many times, was a great and pronounced success on the occasion referred to. The sun shone out in all its softness, the air was mellow with the ripeness of autumn, the foliage with all its changing

hues, and the smokiness of Indian summer weather, all these conspired to make the meeting what it should be.—one of great intellectual effort, and of conspicuous results in advancing the interests of the profession.

It would not be just to our Richmond confrères if we did not tell the world something of the way they received the members and guests of this association. It was literally with open arms that they welcomed them, not only to their charming city, but to their homes and firesides: for the members, in one way or another, were entertained individually or collectively in the drawing-rooms and at the dinner tables of a large number of the resident members of the medical profession. We do not wish to individualize or to speak invidiously, but if we should fail to mention the hospitalities of Dr. Hunter McGuire, Dr. George Ross, and Dr. Geo. Ben. Johnston, we should fail to do justice to our own feelings at least: while the banquet tendered by the entire profession of Richmond, on Thursday night, was a fitting *finale* to a most remarkable week of work and pleasure. Some of the speeches made at the banquet deserve to be preserved in permanent form, because they were unusually witty, bright, entertaining, and instructive.

We must not forget to mention the many kind and delicate attentions to the visitors by Messrs. Carrington and Archer, of the Exchange and Ballard hotels. It is so unusual for guests to receive such personal care as these gentlemen gave to their patrons, that we feel it deserving of record. The Westmoreland Club, too, kept its doors wide open to the visitors.

We regret that we have not space to go more into the details of this meeting, but we close with the assertion that it was one of the best ever held in America. No one who attended it, or who is in the habit of attending other meetings, will dare gainsay this.

The Association honored itself in electing as its president, for the ensuing year, Dr. J. McFadden Gaston, of Atlanta, Ga., and as vice-president, Dr. Cornelius Kolloch, while the Association concluded to take the risk of electing the secretary and treasurer, Dr. W. E. B. Davis and Dr. H. P. Cochrane, of Birmingham, for another year.

The next meeting was appointed to be held in Louisville, Ky., on the second Tuesday of November, 1892.

A NEW REMEDY FOR WHOOPING-COUGH is ouabaine, in doses of about gr. 1-1000. It has been tried with success by Dr. Gemmell, of Glasgow, and, lately, by Dr. J. L. Porteous, of Yonkers, N. Y.—*New York Medical Journal.*

THE EMPIRE STATE EXPRESS.

Within the past month the New York Central & Hudson River Railroad has once more astonished the traveling public by placing at its service the fastest train in the world, which it has appropriately named the Empire State Express. The running time of this train between New York and Buffalo, is eight hours and forty minutes, which gives an average of about fifty-two and a half miles an hour, including stops, a feat that has been accomplished by no other railway in the world, and it is safe to say that it is utterly impossible for any other railroad to approach this speed for so long a distance. Think of it! A passenger may take his breakfast in New York, his luncheon en route, spend three hours in Buffalo and dine at six o'clock leisurely; then take the 8.35 Chicago Limited, and arrive in the city of the Fair next morning to breakfast.

But this is not all; he may take his breakfast in New York, and his dinner at Niagara Falls, arriving at the latter station at 7.20 in the evening. Besides this he may traverse one of the most beautiful regions in the world; along the Hudson he will see the rugged, high banks of the palisades, then the picturesque margin of the river on both sides, dotted here and there with thrifty cities and towns, and finally, before noon, reach Albany, the capital city of the Empire State, which is famous in its old Dutch history; then he bowls along the Mohawk valley for 150 miles at the rate of a mile a minute through one of the most fertile, picturesque, and historic regions in our whole country; he rides through populous cities of 100,000 to 150,000 inhabitants, passes through smart towns of 5,000 to 10,000, each noted for manufacturing and other business enterprises, observes en route the finest agricultural region of the world, and finally reaches Buffalo, not very tired, but just a little hungry, and ready to accomplish a day's work in a couple of hours, and go back by the Buffalo special at 7.30. There is no extra fare charged on this train, and it is only one more and greater convenience that the New York Central, ever ready to oblige its patrons, has placed within the reach of the traveler. There are eleven other splendidly equipped trains daily traversing the State from one end to the other, running over the great four-track road, which has been truly pronounced America's greatest railway.

The equipment of the Empire State Express is the most superb

that can be obtained, and consists of one combination buffet smoking-car, two standard New York Central coaches, and one Wagner buffet drawing-room car, while the entire train is heated by steam, lighted by gas, and possesses all the modern conveniences and luxuries of palatial traveling. Its cuisine supplies the choicest edibles, from which a luncheon is served, and where choice wines and cigars can be obtained at all hours. We hope that this innovation of the New York Central in providing a train with such speed will induce the travelers to ride more in the daytime than heretofore. We are of the opinion that much ill-health is produced by traveling at night, and shall have something to say later upon this subject in the JOURNAL. Our chief point has been especially to call the attention of our readers to the New York Central as offering one of the cheapest, speediest, safest, and most healthful methods of covering the distance between New York and Buffalo.

Physicians are interested in these questions, hence we allude to the subject at some length.

THE APPENDICITIS DISCUSSION OF THE PHILADELPHIA COUNTY MEDICAL SOCIETY.

WE NEED not apologize to our readers for taking up so much space in the present number of the JOURNAL with a discussion of appendicitis. In the first place, it is a subject that every physician must be familiar with, in order that he may recognize the time when the malady passes from the domain of medicine to that of surgery, and to invoke promptly experienced and competent surgical aid. It will not answer now-a-days to treat indifferently recurrent attacks of pain in the right iliac fossa, or to batten down the patient and mask the symptoms in the early stages of the disease, so that the surgeon when he arrives is placed at a disadvantage with reference to the diagnosis, or as to the necessity for operative treatment. The surgeon should early see the case in connection with the physician, not necessarily to operate at once as some have advocated, but rather to become familiar with the case that the opportune moment for operation may be seized if it should present itself, and not have the patient sacrificed because of ignorance, hesitation, or timidity.

We have published in full this remarkable discussion on the subject that took place in the Philadelphia County Medical Society. A special meeting was appointed to be held September 28th, so that Mr. Thomas Bryant, who was visiting this country, might partici-

pate therein. His views, though leaning to the so-called conservative side of the question, deserve careful consideration; but we are of the opinion that the majority of the profession, most familiar with this disease, will, in the main, approve of the position taken by Dr. Morton in this discussion, which is certainly in our present light well nigh impregnable. We bespeak a careful study of this discussion from every point of view, and particularly should the remarks of the speakers following the papers not be omitted in the reading. We could not omit any portion of it without injustice to the speakers, and to divide it with two or three issues of the JOURNAL would spoil its effect, so we have published it to the exclusion of all other original matter. Our contributors will bear with us for the slight delay it occasions in the publication of their articles, we feel sure.

Personal.

DR. ERNEST WENDE, of Buffalo, has been appointed Health Commissioner of this city, under the new charter, which takes effect January 1, 1892. It is understood that Dr. Wende was not an applicant for the place himself, and accepts it upon the urgent solicitation of friends, at great personal sacrifice. It is one of the few instances where the office has sought the man, and is an evidence of progress, for it is difficult to see how it could have made a better choice. Dr. Wende is the leading dermatologist of Western New York, and brings an admirable equipment in education and personal fitness to his new field. We hope he will enjoy his official work, but hardly understand how he can afford to abandon his large special practice for even so tempting an office.

DR. W. E. B. DAVIS, of Birmingham, Ala., was elected president of the Tri-States Medical Association at the recent meeting, held in Chattanooga, Tenn. Dr. Davis is an accomplished physician and an experienced presiding officer,—two good reasons why it may be expected that his administration of the affairs of the Association will prove successful in the highest degree.

PROF. W. T. BRIGGS, his many friends will be glad to learn, has fully recovered from his recent severe illness, and is able to attend to business again.—*Nashville Jour. of Med. and Surg.*

Dr. C. A. L. Reed read a paper at the eighty-fifth annual meeting of the Medical Society of the State of New York, upon The Surgical Treatment of Ectopic Gestation. The article was published in the *New York Medical Journal*, of June 6, 1891. The paper is full of good points, and can safely be regarded as a real contribution to our knowledge upon this subject. We advise all who are interested in the subject to read this article and judge for themselves.—*Lancet-Clinic*.

Dr. John A. Pettit, of Buffalo, has been appointed Deputy Health Commissioner under the new charter. Health Commissioner Wende shows his fitness for his new position in this first official act. Since Dr. Pettit is entirely competent for the chief position, there cannot be two opinions as to his ability to perform the duties of deputy in a thorough-going manner. When the head of a department selects able and honest men for subordinate places, his successful administration is more than half assured.

Dr. Wm. A. Wheeler, United States Marine Hospital Surgeon, formerly of this city, and now of Norfolk, Virginia, visited Buffalo last month, and received a most cordial welcome among his many friends. Dr. Wheeler justly deserves the reputation of being one of the most accomplished surgeons in the service, and we join in the high estimation in which he is held both here and elsewhere in and out of the service.

Journalistic Notes.

The New York *Journal of Gynecology and Obstetrics* has made its appearance. It is to be issued monthly, to contain sixty-four pages, and is of standard octavo size. The editors are Dr. A. H. Buckmaster and Dr. J. D. Emmet. In addition to original communications, editorials, society proceedings, etc., the November number contains a beautiful portrait of the late Dr. Fordyce Barker as a frontispiece.

The *American Gynecological Journal* is the new name of the former *Journal of Gynecology*. This journal is fast making a name, and has already established itself permanently as one of the necessary special periodicals. It is edited and published by Dr.

Charles N. Smith, of Toledo, O., with the following corps of associate editors: Joseph Price, M. D., Philadelphia; Lewis S. McMurtry, M. D., Louisville, Ky.; Andrew F. Currier, M. D., New York; Walter P. Manton, M. D., Detroit, Mich.; Charles A. L. Reed, M. D., Cincinnati, O.; Henry T. Byford, M. D., Chicago, Ill.; Florian Krug, M. D., New York; William E. B. Davis, M. D., Birmingham, Ala.

Society Meetings.

The Buffalo Clinical Society held its first meeting, for organization, Saturday evening, November 21, 1891, at the Niagara Medical College building, on Ellicott street. The officers are: President, Dr. John H. Pryor; Vice-President, Dr. Eugene H. Smith; Secretary and Treasurer, Dr. M. V. Ball; Councilmen: (three years) Dr. A. A. Hubbell, (two years) Dr. W. H. Heath, (one year) Dr. H. M. Mickle. Meetings will be held on the first Saturday in each month, at the Niagara Medical College building.

The eighty-sixth annual meeting of the Medical Society of the State of New York will be held at Albany, Tuesday, Wednesday, and Thursday, February 2, 3, and 4, 1892. Dr. Seneca D. Powell, No. 12 West 40th street, New York, Dr. James D. Spencer, of Watertown, and Dr. Franklin Townsend, No. 2 Park place, Albany, have been appointed the Business Committee. Any communications regarding papers, or any matter pertaining to the business of the Society, which may properly come before the Business Committee, should be addressed to Dr. Seneca D. Powell, Chairman, 12 West 40th street, New York City.

A. WALTER SUITER,
President.

F. C. Curtis,
Secretary.

The Hudor Company manufactures bottled high grade mineral waters and carbonated beverages for table, club, and medicinal uses. The advertisement of this enterprising company appears on page 24, to which we respectfully call the attention of our readers. Physicians who are in the habit of prescribing lithia, seltzer, vichy, and other waters, cannot fail to obtain the promptest and best service from this company. Their lithia water and ginger ale are especially to be commended as of the best in the market.

Book Reviews.

ON THE MEDICAL AND SURGICAL USES OF ELECTRICITY. By GEO. M. BEARD, A. M., M. D., and A. D. ROCKWELL, A. M., M. D., Formerly Professor of Electro-Therapeutics in the New York Post-Graduate Medical School and Hospital; Fellow of the New York Academy of Medicine; Member of the American Academy of Medicine; Member of the New York Neurological Society; formerly Electro-Therapeutist to the Woman's Hospital of the State of New York, etc. Eighth edition, with over two hundred illustrations. 788 pp., cloth. New York: William Wood & Co.

This work has been before the public for over ten years, and in that time it has established a place for itself in electro-therapeutic literature.

The volume is divided into four parts, treating respectively of electro-physics, electro-physiology, electro-therapeutics, and electro-surgery. In the section devoted to electro-physics, magnets, frictional, galvanic and faradic electricity, are discussed, and the properties of each, and method of producing them, explained. Ohm's law, and its practical relation to electro-therapeutics, has a well-written chapter devoted to it.

In the section on electro-physiology, the action of electricity on the skin, brain, spinal cord, sympathetic, pneumogastric optic, auditory and gustatory nerves, is detailed with great care, and supported by the experiments of such men as Brenner, Fenier, Hitzig, Claude Bernard, and others.

Other chapters in this section treat of the effect of electricity on voluntary and involuntary muscles on the motor and sensory nerves. This section is very complete, and of great importance, as no one can properly use a therapeutic agent until he understands its physiological action, and surely electricity is no exception to this rule.

When we take up the section on electro-therapeutics, we are impressed with the number of diseases for which electricity has been employed, and the variety of effects which may be expected from the various methods of application.

A strong plea is made for the tonic property of central galvanization and general faradization.

We quote from page 200: "The very marked permanent effect is improvement in sleep. They permanently improve the appetite and digestive capacity, and regulate the bowels." Agreeing, as we do, with the authors, that these effects result from electrical

treatment, we must dissent from the statement that the improvement is permanent.

When we come to the treatment of special diseases, we must admit that in some instances we are puzzled as to the authors' meaning, as, on page 578, we read of infantile paralysis: "There is probably no one pathological lesion that is pathognomonic of the disease." We have been of the opinion that it was now an accepted fact that the lesion in the anterior cornea was a pathognomonic one.

In many instances the authors will refer to the use of electricity for a certain condition, and then report a single case, as, on page 613, we read that "Ptosis is to be treated like spasm of the lid (its opposite condition), but with a stronger current." A single case is then reported of ptosis, following herpes, cured under galvanization. This was a case of ptosis due to an acute affection, and belonged to the class of readily curable cases. But the reader should not be left to infer that, as a rule, ptosis is easily cured, for it is not, the third nerve being very difficult to treat.

On reading the page devoted to Paralysis Agitans, we read that there are two kinds: 1st. Those with organic lesions. 2d. Those where no functional lesions can be discovered. Of the treatment of this progressively incurable affection, we read, "that central galvanization and general faradization may be used with benefit. The best results have been obtained by galvanization of the spine and sympathetic and brain." "The best results" is a misleading expression, as, unfortunately, no results in paralysis agitans are entitled to the words, best results.

If there is any one criticism which we think is especially called for, it is the general looseness of expression when speaking of results. In the page given to epilepsy, three cases are reported, one marked apparent recovery. Of this patient we read that when they received the patient, she had been taking the bromides for several years, and they then gave her Brown-Sequard's formula, and electrical treatment; result, apparent recovery. This is not a fair case for us to quote as a proof that electricity will benefit epilepsy.

In the last section, devoted to electro-surgery, much of interest and value is found. The technique of electrolysis for the various growths, and the use of the galvano-cautery, are admirably presented.

The book, as a whole, is one of the most complete of its kind, and one can hardly fail to find within its pages anything on medical electricity, in all its branches.

Most of us will not agree with the authors in all their fond hopes, and for that reason we shall be less liable to disappointment.

The illustrations and type are excellent. J. W. P.

INSOMNIA, AND ITS THERAPEUTICS. By A. W. MACFARLANE M. D. Fellow of the Royal College of Physicians, Edinburgh; Fellow of the Royal Medical and Chirurgical Society of London; Examiner of Medical Jurisprudence in the University of Glasgow; Hon. Consulting Physician (late Physician) Kilmarnock Infirmary; formerly Examiner in Medicine and Clinical Medicine in the University of Glasgow, etc., etc. Reprinted from Wood's Medical and Surgical Monographs. 294 pages, octavo, cloth. New York: William Wood & Co. 1891.

There are few ills of humanity which he may be called upon to relieve, that give more trouble and anxiety to the physician than the class of symptoms known under the general head of insomnia. As it is not a disease *per se*, whose pathogenesis may be reached by direct means, the cause must be found among the numerous ailments which more or less remotely affect the nervous organism. The first chapter is devoted to a careful examination of the physiology of sleep. Attention is called to the latest studies which prove the anemical state of the brain during sleep, and a clear idea is given of its gradual effect upon its various centers. "Briefly summarized (Dr. Macfarlane says), during sleep the brain, ganglia, medulla, and cord, are in a state of repose: and the work of the economy is conducted with the smallest possible expenditure of energy." The gradual onset of sleep is carefully noted and intelligently stated, while dreams, their value as a means of diagnosis, somnambulism and hypnotism, are briefly dwelt upon. Much is also said about the conditions which influence sleep and sleeplessness, and interesting cases in the author's own practice are given in a tabular form, with general directions as to treatment and removal of exciting causes.

In regard to the treatment of insomnia and its therapeutics, several chapters are devoted to the various exciting causes. Everything which bears upon the subject seems to be scientifically and fairly treated. The difference between individual idiosyncracies is abundantly recognized, and though much must necessarily be simply theoretical, the author is careful to separate the *known* from the unknown, or even problematical. Among the causes for insomnia are given: overwork, neurasthenia, spasmodic and paroxysmal neuroses, with many other affections of the nervous

system, and toxic agents. Several chapters are devoted to affections of the alimentary canal; others pay attention to the circulatory system, the respiratory system, febrile diseases, affections of the urinary system, and the insomnia peculiar to females. In each of these, therapeutic formulas adapted to the case are given, where simple hypnotics may be valueless or contra-indicated.

While we discover nothing in the book which is not already known to the well-educated physician, we think Dr. Macfarlane has rendered the profession a signal service in his analytical method of grouping together the essential facts bearing upon the subject, and to the practitioner who is debarred from access to the specialist, his suggestions, directions, and prescriptions, ought to be of very great value. The author's style is that of a man well up in his subject, clear, and with a terseness which, not too brief, loses nothing of its grace.

SURGERY: A PRACTICAL TREATISE, WITH SPECIAL REFERENCE TO TREATMENT. By C. W. MANSELL MOULLIN, M. A., M. D., Oxon. Fellow of the Royal College of Surgeons; Surgeon and Lecturer on Physiology to the London Hospital; formerly Ratcliffe Traveling Fellow and Fellow of Pembroke College, Oxford, England. Assisted by various writers on special subjects. With 500 illustrations, 200 of which have been made for this work from special drawings. Octavo, pp. viii.–1180. Philadelphia: P. Blakiston, Son & Co. 1891. Buffalo: Peter Paul & Brother.

The purpose of the author in this volume is to give an epitome of modern surgery, in which theories and disputed opinions are subordinated to practical surgery. The author adopts the somewhat novel but excellent method of describing under the head of each organ the malformations to which it is liable, and the various operations that may be performed upon it, rather than putting such matters in separate chapters. In the author's opinion, "the chief aim and object of surgery at the present day, is to assist the tissues in every possible way in their struggle against disease," and this idea pervades the entire book. He first discusses the general pathology of surgical diseases, including injury and repair, diseases due to non-infective and infective organisms and tumors; then the general pathology of injuries, the general and local effects of injury, burns and scalds, coming under this heading; and, finally, the diseases and injuries of special structures are considered concisely but comprehensively, and this portion makes up the large bulk of the work. The pathology and treatment, as given in the work, are

modern, the latter in the main showing a very happy combination of the conservative and the radical. Good practical hints, evidently the result of a large experience in surgery, abound and add much to the value of the book. Some curious omissions occur in a work bearing the date of 1891, such as the non-recognition of the chisel and gouge as a safe and rapid way of entering the skull, and of open arthrotomy in irreducible recent dislocations of some joints, but in the main the book is essentially up to date, and well worth a place in every physician's library.

The illustrations are numerous—some five hundred in all—of which two hundred were made from special drawings for this work. They are excellent for the most part, and illustrate the meaning of the text very clearly. The publishers are to be congratulated on the successful part they have played in giving this valuable work to the profession. J. P.

PRACTICAL TREATISE ON ELECTRICITY IN GYNECOLOGY. By EGBERT H. GRANDIN, M. D., Chairman Section on Obstetrics and Gynecology, New York Academy of Medicine; Obstetric Surgeon, New York Maternity Hospital; Obstetrician New York Infant Asylum, etc., and JOSEPHUS H. GUNNING, M. D., Instructor in Electro-Therapeutics, New York Post-Graduate Medical School and Hospital; Gynecologist to Riverview Rest for Women; Electro-Gynecologist North-Eastern Dispensary, etc. Illustrated. Octavo, 180 pages. Muslin. $2.00. New York: William Wood & Company. 1891.

In regard to the application of electricity to the treatment of disease, especially as to the propriety of its use in gynecology, there will ever be two opinions. The operating surgeon will naturally claim to do better justice to his patients through the medium of the knife, dealing with conditions that he can both see and feel with his educated eyes and finger-tips. On the other hand, the physician who has not the taste or skill to do successful surgical work will naturally turn to electricity to aid him in the management of his cases. Since we must meet conditions as they are and not fit a fact to a theory, it is well for us to have some of the best literature possible to serve us as a guide to the application of an unknown quantity, like electricity, to the treatment of known diseases such as are met with by the gynecologist.

The authors of the book before us are entitled to the credit of having prepared the best treatise that has appeared up to the present time in this country on the subject of its title. The section of the book given to general conditions and descriptions of apparatus

comprising the first fifty-four pages, is a *résumé* of what is generally found in the books on electricity. This section is illustrated with the usual number of cuts of apparatus. The next chapter on the routine uses of electricity contains much valuable advice with reference to that branch of the subject, and will well repay careful reading. The remaining chapters on electrolysis, static electricity, and the treatment of malignant growths by the galvano-cautery, and electricity in obstetrics, are all well written, and should command attention by reason of the honesty and ability of the authors, no matter whether the reader finds himself agreeing with them on all points or not. The book is well printed and closes with an index, which, though somewhat meagre, is, perhaps, ample for all practical purposes. As we said at the beginning, taken all in all, this is the best book on the subject that has yet appeared from an American press.

THE MEDICAL NEWS VISITING LIST FOR 1892. Weekly (dated, for thirty patients); Monthly (undated, for 120 patients per month); Perpetual (undated, for thirty patients weekly per year); and Perpetual (undated, for sixty patients weekly per year). The first three styles contain thirty-two pages of data and 176 pages of blanks. The sixty patient Perpetual consists of 256 pages of blanks. Each style in one wallet-shaped book, pocket, pencil, rubber, and catheter scale, etc. Seal grain leather, $1.25. Philadelphia: Lea Brothers & Co 1891.

This list has been thoroughly revised and brought up to date in every respect. The text portion (thirty-two pages) contains the most useful data for the physician and surgeon, including an Alphabetical Table of Diseases, with the most approved Remedies, and a Table of Doses. It also contains sections on Examination of Urine, Artificial Respiration, Incompatibles, Poisons and Antidotes, Diagnostic Table of Eruptive Fevers, and the Ligation of Arteries. The classified blanks (176 pages) are arranged to hold records of all kinds of professional work, with memoranda and accounts. Four styles are now published: weekly (dated, for thirty patients); monthly (undated, for 120 patients per month, and good for any year); perpetual (undated, for thirty patients weekly per year); and perpetual (undated, for sixty patients weekly per year). This last style consists of 256 pages of assorted record blanks, without text. The Medical News Visiting List adapts itself to any system of keeping professional accounts. Each style is in one volume, bound in handsome red leather, with pocket, pencil, rubber, and catheter-scale. Price, $1.25. When desired, a

Ready Reference Thumb-letter Index is furnished, which is peculiar to this Visiting List, and will save many-fold its small cost (twenty-five cents) in the economy of time effected during a year. In short, every need of the physician seems to have been anticipated in the Medical News Visiting List.

STORIES OF A COUNTRY DOCTOR. By WILLIS P. KING, M. D., Member of the American Medical Association; Member and ex-President of the Missouri State Medical Association; Assistant Chief Surgeon of the Missouri Pacific Railway Company; formerly Lecturer on Diseases of Women in the Medical Department of the Missouri State University, and Professor of Diseases of Women in the Medical Department University of Kansas City; Lecturer on Orthopedic Surgery and Clinical Surgery in the University Medical College of Kansas City, etc., etc. Second edition. With illustrations by T. A. Fitzgerald. Philadelphia: A. L. Hummel, M. D. publisher. 1891. Price, $1.00, bound in cloth.

When the first edition of this book appeared we hardly expected to be called upon to notice it again so soon. This fact is sufficient evidence that it has a place in the heart of the profession, hence the cry for more and more as soon as the supply is exhausted. We expressed our opinion of the book so freely and, we may say, so completely before, that we hardly know how to add to, and we certainly cannot retract from, our previously expressed judgment. Every physician must have some work in his library that diverts the mind, and through that means bring rest to the body. Dr. King's book affords just the sort of reading to do this, and it has now been reduced to the nominal price of one dollar, which brings it within easy reach of almost every pocket. The publisher, Dr. A. L. Hummel, of Philadelphia, has dressed it up in a neat and practical attire, leaving nothing to be desired on that score. We again commend it to the profession as a work of light literature that is seldom equaled and still more rarely excelled.

SYLLABUS OF THE OBSTETRICAL LECTURES IN THE MEDICAL DEPARTMENT OF THE UNIVERSITY OF PENNSYLVANIA. By RICHARD C. NORRIS, A. M., M. D., Demonstrator of Obstetrics, University of Pennsylvania; Physician to the Methodist Episcopal Hospital; Obstetrical Registrar Philadelphia Hospital. Second edition. Philadelphia: W. B. Saunders. 1891. Price, $2.00.

This work, the author states, is a necessity. The difficulty in note-taking in medical lectures is recognized by all medical students. In obstetrics, through the use of the manikin and plates to illustrate the subject, the difficulty complained of cannot be as

great as in other branches, but even here the author attempts to aid the student, by furnishing the salient points of each lecture, arranged in a consecutive order, with a view to assist in the subsequent study of the subject. After a careful examination, we think the work will subserve a good purpose. It contains a vast amount of well-digested matter, thoroughly condensed and clearly presented. Teachers realize that in the pressure and work of the session, in which the student has but a limited time to devote to the many subjects to which he listens daily: thus he will find in this little book an invaluable aid for his preparation for quizzes and examinations.

The author has performed the task assigned him, in giving a digest of Prof. Hirst's lectures, in a manner creditable alike to himself and to the teacher whose lectures he aims to epitomize.

ESSENTIALS OF ANATOMY AND MANUAL OF PRACTICAL DISSECTION, TOGETHER WITH THE ANATOMY OF THE VISCERA. Prepared especially for Students of Medicine. By CHARLES B. NANCREDE, M. D., Professor of Surgery and of Clinical Surgery in the University of Michigan, Ann Arbor; Corresponding Member of the Royal Academy of Medicine, Rome, Italy; late Senior Surgeon to Episcopal Hospital; late Surgeon to Jefferson Medical College Hospital; formerly Lecturer on Osteology, etc., in Medical Department, University of Pennsylvania; late Professor of General Orthopedic Surgery in Philadelphia Polyclinic, etc. Fourth edition, revised and enlarged by an Appendix containing Hints on Dissection, by J. CHALMERS DA-COSTA, M. D., based upon the last edition of Gray's Anatomy. Thirty handsome full-page lithographic plates in colors, and 188 fine wood-cuts. Philadelphia: W. B. Saunders, 913 Walnut street. 1891.

The usefulness of this book to the medical student pursuing his anatomical course, can scarcely be overstated. The practical hints on dissection are so clear and simple that it seems to us that no one of ordinary intelligence can fail to follow them with ease. Thirty beautifully executed colored lithographs illustrate the most important parts in medical or surgical points of view. Taken all in all, nothing appears to be wanting to make it an excellent companion to the scalpel at the dissecting table. The larger part of the book is devoted to what its author calls the Essentials of Anatomy, an arrangement in the form of questions and answers, and it is safe to say that the student who can answer all these questions correctly, may fearlessly face the examiner in anatomy when the crucial trial comes. Excellent wood-cuts illustrate the text.

THE GENUINE WORKS OF HIPPOCRATES. Translated from the Greek, with a Preliminary Discourse and Annotations. By FRANCIS ADAMS, LL. D., Surgeon. Octavo, 766 pages, extra muslin, gilt top, price, $5.00. New York: William Wood & Company. 1891.

Every physician should commune with the fathers of medicine, and particularly with the great Hippocrates, who may be justly regarded as the most learned of them all. Very few physicians in active practice can command sufficient time to read medical classics in their original tongue. Hence, it is a pleasure and a profit to be able to read these works in a modern language. The council of the Sydenham Society did wisely in selecting Dr. Adams to translate such of the most important works of the great father of medicine as appear in the volume before us. The translator has illustrated his labor by annotations, arguments, and such-like methods which are given in the way of foot notes. This adds much to the interest of the book and serves to explain many obscure points, because we thus are able to obtain the opinion of a scholar upon doubtful and technical phrases. The publishers have presented this book as an *edition de luxe*, bound in mottled linen boards with gilt borders and untrimmed edges, which, together with the excellent paper and press-work, make it one of the most beautiful that have been issued for physicians by any American press.

CHEMICAL LECTURE NOTES. Taken from Prof. C. O. CURTMAN'S Lectures at the St. Louis College of Pharmacy. By H. M. WHELPLEY, M. D., Ph. G., F. R. M. S., Professor of Microscopy and Quiz Master of Pharmacognosy and Botany in the St. Louis College of Pharmacy, etc. Third edition, with over one hundred illustrations. Pp. 211. Published by the author.

This is one of the most complete set of lecture notes we have seen for some time. It is an excellent work, replete with information given in a clear and concise manner. It is just the kind of a book for a quiz master, or for the busy professional man who wants to brush up his knowledge of chemistry, which has grown dim from lack of use. J. A. M.

THE PHYSICIAN'S VISITING LIST (LINDSAY & BLAKISTON'S) FOR 1892. The forty-first year of its publication. Philadelphia: P. Blakiston, Sons & Co., 1012 Walnut street. Price, from $1.00 to $3.00, according to size.

This standard Visiting List is one of the first to put in its appearance, and is easily seen to be one of the best. It is simple in its arrangement, and at the same time sufficiently large to meet

all the requirements of the busy physician. It is published in several fashions, to-wit: A monthly edition, a perpetual edition, an interleaf edition, and a regular edition. It is bound in substantial morocco, and each book is supplied with one of Blakiston's lead pencils with eraser. We need not enumerate the table of contents, for it does not differ greatly from others in respect to this preliminary matter, but for compactness, simplicity of arrangement, and completeness of detail, it is not excelled by any visiting list in the market.

PHYSICIAN'S LEISURE LIBRARY. Electricity: Its Application in Medicine and Surgery. A brief and practical exposition of modern scientific electro-therapeutics. By WELLINGTON ADAMS, M. D., author of Art of Telephony—By Whom Discovered; Evolution of the Electric Railway; Designs and Construction of Dynamo-Electric and Electro-Dynamic Machinery. Lecturer on Electro-Therapeutics, University Medical College, Kansas City; formerly Professor of Diseases of the Ear, Nose and Throat, Medical Department, University of Denver, and Editor *Rocky Mountain Medical Review*. In three volumes. 1891. George S. Davis, Detroit, Mich.

Parts one and two, which have appeared, are devoted to the description of the different batteries, electrodes, and general electrical paraphernalia. The volumes show that the writer is thoroughly familiar with the technique of electrical apparatus. We await, with great hopes, the publication of the third volume, which is to deal with the use of electro-therapy. J. W. P.

MASSAGE: A PRIMER FOR NURSES. By SARAH E. POST, M. D., Lecturer before the Training Schools for Nurses, connected with Bellevue, Mt. Sinai, St. Luke's, and Charity Hospitals, New York. Second edition, with seven original photographs; 12mo, pp. 47. New York: The Nightingale Publishing Company. 1891.

In this little volume the subject of Massage is treated in a manner that none but a master of the art could do. The author wastes not a single word, but with a lucidity born of intelligent practice, she imparts her knowledge so plainly that it would seem as if any good and healthy individual may almost at once become expert. The only drawback would be ignorance of human anatomy. Though especially for nurses, the book ought to be in every house — if for no other reason — to prevent mischief by ignorance.

BOOKS AND PAMPHLETS RECEIVED.

A Text-book of Physiology. By M. Foster, M. D., LL. D., F. R. S., Professor of Physiology in the University of Cambridge, England. Fourth American, from the fifth English edition, thoroughly revised. Octavo, 1072 pages, 282 engravings. Cloth, $4.50; leather, $5.50. Philadelphia: Lea Brothers & Co. 1891.

A Practical Treatise on the Diseases of Women. By T. Gaillard Thomas, M. D., LL. D., Emeritus Professor of Diseases of Women in the College of Physicians and Surgeons, New York, and Paul F. Mundé, M. D., Professor of Gynecology in the New York Polyclinic. New (sixth) edition, thoroughly revised and rewritten by Dr. Mundé. In one large and handsome octavo volume of 824 pages, with 347 illustrations. Cloth, $5.00; leather, $6.00. Philadelphia: Lea Brothers & Co. 1891.

Ptomaines and Leucomaines and Bacterial Proteids, or The Chemical Factors in the Causation of Disease. By Victor C. Vaughan, Ph. D., M. D., Professor of Physiological and Pathological Chemistry, and Associate Professor of Therapeutics and Materia Medica, in the University of Michigan, and Frederick G. Novy, M. D., Instructor in Hygiene and Physiological Chemistry in the University of Michigan. New edition. In one handsome 12mo volume of 380 pages. Cloth $2.25. Philadelphia: Lea Brothers & Co. 1891.

Manual of Chemistry. A Guide to Lectures and Laboratory Work for Beginners. A Text-book especially adapted for Students of Pharmacy and Medicine. By William Simon, Ph. D., M. D., Professor of Chemistry and Toxicology in the College of Physicians and Surgeons, Baltimore, and Professor of Chemistry in the Maryland College of Pharmacy. New (third) edition. In one octavo volume of 477 pages, with forty-four wood-cuts and seven colored plates illustrating fifty-six of the most important chemical tests. Cloth, $3.25. Philadelphia: Lea Brothers & Co. 1891.

The Comparative Anatomy of the Domesticated Animals. By A. Chauveau, M. D., LL. D., Member of the Institute (Academy of Sciences); Inspector-General of Veterinary Schools in France; Professor of the Museum of Natural History, Paris. Revised and enlarged, with the coöperation of S. Arloing, Director of the Lyons Veterinary School, Professor of Experimental and Comparative Medicine at the Lyons Faculty of Medicine. Second English edition, translated and edited by George Fleming, C. B., LL. D., F. R. C. V. S., Late Principal Veterinary Surgeon of the British Army; Foreign Corresponding Member of the Société Royal de Medicine, and the Société Royal de Medicine Publique, of Belgium; Foreign Associate of the Société Centrale de Medicine Veterinaire of France; Honorary Life Member of the Royal Agricultural Society of England; Foreign Member of the Société Nationale d'Agriculture of France, etc.; Examiner in Anatomy for the Royal College of Veterinary Surgeons. With 585 illustrations. New York: D. Appleton & Co. 1891.

Essentials of Nervous Diseases and Insanity: Their Symptoms and Treatment. A Manual for Students and Practitioners. By John C. Shaw, M. D., Clinical Professor of Diseases of the Mind and Nervous System, Long Island College Hospital Medical School; Consulting Neurologist to St. Catherine's Hospital, and Long Island College Hospi-

tal; formerly Medical Superintendent King's County Insane Asylum. Forty-eight original illustrations, mostly selected from the author's private practice. Philadelphia: W. B. Saunders, 913 Walnut street. 1891.

Annual Report of the State Board of Charities for the Year 1890. Transmitted to the Legislature, February 5, 1891. Albany: James B. Lyon, State Printer. 1891.

Bureau of Education, Circular of Information No. 1, 1891. Contribution to American Educational History. Edited by Herbert B. Adams. No. 10. Higher Education in Indiana. By James Albert Woodburn, Ph. D., Professor of American History in the Indiana University; Sometime Fellow in History, John Hopkins' University. Washington: Government Printing Office. 1891.

Addresses, Papers and Discussions, in the Section of State Medicine, at the Forty-second Annual Meeting of the American Medical Association, at Washington, D. C., May 5 to 8, 1891. Chicago: Printed at the office of the Association. 1891.

Addresses, Papers and Discussions, in the Section of Otology and Laryngology, at the Forty-second Annual Meeting of the American Medical Association, at Washington, D. C., May 5 to 8, 1891. Chicago: Printed at the office of the Association. 1891.

Post-Partum Douche (showing new instrument). By Edwin Pynchon, M. D. Read before the Chicago Medical Society, September 7, 1891.

An Abstract of the Symptoms, with the Latest Dietetic and Medicinal Treatment, of Various Diseased Conditions. The Food Products. Digestion and Assimilation. The New and Valuable Preparations manufactured by Reed & Carnrick, 447 and 449 Greenwich street, New York.

A Clinical Report of Operative Surgery in the Service of Dr. William T. Bull. At the New York Hospital during October and November, 1889, and from February to June, 1890. By Wm. B. Coley, M. D., Late House Surgeon. Reprint: *New York Medical Journal* for April 18 and 25, May 2 and 30, June 20, and August 29, 1891.

Addresses, Papers and Discussions, in the Section of Oral and Dental Surgery, at the Forty-second Annual Meeting of the American Medical Association, at Washington, D. C., May 5 to 8, 1891. Chicago: Printed at the office of the Association. 1891.

Experiments and Researches on Trap Siphonage, Showing the Comparative Merits of the Principal Appliances used for Trap-Seal Protection. By James M. Denton, M. E., Professor of Experimental Mechanics in Stephens' Institute of Technology, Hoboken, N. J. Presented at the Eighteenth Annual Meeting of the American Public Health Association, Charleston, S. C., December 16-19, 1890. Reprint from Vol. XVI. of the Transactions of the American Public Health Association.

Bald Heads. By Albert E. Carrier, M. D., Detroit, Mich. Reprint: Transactions of Michigan State Medical Society. 1891.

Bulletin of the Buffalo Society of Natural Sciences. Buffalo: Reinecke & Zesch, 500 Main street. 1891.

Advantages of Mixed Narcosis in Gynecological Surgery. By J. C. Reeve, M. D., Dayton, Ohio. Reprint: Transactions of the American Gynecological Society, September, 1891.

Cornell University Agricultural Experiment Station. Bulletin 32. Horticultural Division. October, 1891. Tomatoes Published by the University, Ithaca, N. Y. 1891.

A Report of Ten Selected Cases on Laparatomy, with Remarks By John H. McIntyre, A. M., M. D., of St. Louis Mo. Reprint: *The Journal of the American Medical Association.*

Case of Gonorrheal Pyosalpinx. Rare Source of Infection (with plate 1). By Z. H. Evans, M. D., Bay City, Mich. Reprint: *Annals of Gynecology and Pediatry*, August, 1891.

The Statistics and Lessons of Fifteen Hundred Cases of Refraction. By George M. Gould, M. D., Ophthalmologist to the Philadelphia Hospital, Philadelphia, Pa. Read in the Section on Ophthalmology, at the Forty-second Annual Meeting of the American Medical Association, held in Washington, D. C. May, 1891. Reprint: *Journal of the American Medical Association*, September, 1891.

Hypnotism versus Morphinism. By William Lee Howard, M. D. Baltimore, Md. Reprint: *Baltimore Medical and Surgical Record* June and July, 1891.

The Twenty-second Annual Report of the President of the Inebriates' Home, Fort Hamilton, N. Y., for the year 1889. Brooklyn: 1890.

On the Treatment of Diphtheria in America. By A. Jacobi New York. Sonderabdruck aus den Verhandlungen des X. Internationalen Medicinischen Congresses. Berlin: Gedruckt bei L. Schumacher.

Extracranial Aneurism. By A. Jacobi, New York. Sonderabdruck aus den Verhandlungen des X. Internationalen Medicinischen Congresses. Berlin: Gedruckt bei L. Schumacher. 1891.

On Dermatol, a Proposed Substitute for Iodoform. Its Use in Surgical Practice. By Charles A. Powers, M. D., Surgeon to the Out-patient Department, New York Hospital; Instructor in Surgery, New York Post-Graduate Medical School and Hospital. Reprint: *The Medical Record*, October 17, 1891.

Some Facts every Practitioner Ought to Know about Squint. By Alfred Rufus Baker, M. D., Cleveland.

HEALTH BULLETINS.

Michigan State Board of Health. October, 1891.

Meeting of the Michigan State Board of Health. October, 1891.

Progress in Public Health Work in Michigan November 9, 1891.

Newport, R. I., *Health Bulletin*. Report of Deaths and Contagious Diseases. October, 1891.

New York State Board of Health. September, 1891.

State Board of Health of Tennessee. October, 1891.

Abstract of Sanitary Reports, U. S. Marine Hospital Service. Vol. VI. Nos. 43, 44, 45, 46, and 47.

Miscellany.

THE *Obstetrical Record*, published by the New York Pharmacal Association, comprises a chart for the accurate report of obstetric cases. It aims to secure (1) a complete history of the patient, her

age, name, nativity, residence, occupation, religion, married or single. 2. Previous labors, their duration, operative interference, complications, sequelæ, lactation and its complications, condition of child. 3. Present pregnancy, with time of quickening; expected date of confinement; examination of urine; examination, vaginal and by palpation, pelvimetry, complications and general therapeutic measures. 4. Present labor, date, duration, anesthetic used and character of pains, presentation and position, operative measures and complications. 5. A chart for the temperature and pulse, after-treatment, lactation, sex, condition of child and diameter of fetal head.

The object of this record is to encourage the accoucheur in the habit of accurate note-taking. We commend the design, and think the plan here presented will, by its simplicity, prove a ready help to the busy practitioner in making a complete history of his obstetric cases. If such a chart could be more generally adopted and carefully filled out, we would have more scientific work and better and more reliable statistics in obstetrics.

All Around the Year 1892.—Entirely new design, in colors, by J. Pauline Sunter. Printed on heavy cardboard, gilt edges, with chain, tassels, and rings. Size, 4½ by 5½ inches. Boxed. Price, 50 cents. Lea & Shepard, Boston, Mass.

This is a most charming calendar, tastily tied with a white silk cord, with a delicate silver chain attached. The cards representing the months are arranged on rings, so that they can be turned over as each month is needed for reference. It is as fresh in design as it is fresh in the fair whiteness of its workmanship. Each card contains not only the calendar, but a design both charming and appropriate, and an equally timely sentiment. The drawings are in Mrs. Sunter's picturesque style, and executed in sepia tint and color.

Altogether it is a charming piece of work, a thorough pleasure to the eye, and sure to win a welcome wherever it goes.

WANTED—The Berlin Royal Library wishes to complete its file of the Buffalo Medical and Surgical Journal and advertises for Vols. I. to XXVIII. inclusive, of the new series, and the fifteen volumes of the old series. All inquiries on the subject of back numbers and prices should be addressed to the Managing Editor, 284 Franklin street, Buffalo, N. Y.

FOR SALE—Valuable Medical Library and Surgical Instruments for sale cheap. Address, Mrs. B. A. Fuller, LeRoy, N.Y.

Buffalo Medical and Surgical Journal

Vol. XXXI. JANUARY, 1892. No. 6.

Original Communications.

THE PREVENTION OF TUBERCULOSIS.

By HENRY R. HOPKINS M. D., Buffalo, N. Y.,

Professor of Hygiene, Medical Department University of Buffalo.

"Millions for defense, but not one cent for tribute."—*Pinckney.*

It may truthfully and pertinently be said that, as a people, we Americans are mightily absorbed in moneygetting and in money-spending display. Any new thought, no matter how intrinsically important it may be, which for a moment distracts or occupies the busy American from his favorite pastime of moneygetting or display, finds it exceedingly difficult to get a hearing. In no department of economics is this peculiarity more distinctly marked than in the department of public health.

It would be easy and natural to suppose that the medical profession would be entirely exempt from any such pre-occupation as we have just referred to, and that any new discovery or any important statement of truth in such a preëminently practical direction as the prevention of disease, would find the medical profession not only eager to hear but quick to act. The study of state medicine, the practical work in the prevention of disease, only too clearly illustrates that the medical profession is human in its membership, and being human reflects quite too frequently the indifference of the community from which this medical profession springs and among which it labors. These reflections come to the writer's mind in the attempt to concentrate a few thoughts upon the most pertinent question in state medicine,—the prevention of tuberculosis.

Let me remind my readers that it is now nearly a quarter of a century since Villemin gave to the world the results of his interesting original experiments, in which he, in the most masterly manner, demonstrated the inoculability of tuberculosis. As the

result of this original and preëminently important work, Villemin announced: First—As declared by Bayle and Lænnec, tuberculosis is a specific disease. Second—As demonstrated by myself, tuberculosis is an inoculable disease and must take its place among the virulent diseases, small-pox, scarlet fever and syphilis. Third—That tuberculosis arises by direct inoculation, by contagion, that its contagia are germs contained in the tuberculous matter or floating in the air. I would also remind my readers that in October, 1867, there appeared in the *London Lancet*, a publication by Dr. Wm. B. Budd, of England, which publication, rightly appreciated and loyally adopted, should have been a chart and compass for every board of health, municipal, state or national, as well as the guiding star for every individual member of the medical profession in the civilized world so far, at least, as the subject of tuberculosis is concerned. I give Dr. Budd's conclusions complete:

First: That tuberculosis is a true zymotic disease of specific nature in the same sense that typhoid fever, scarlet fever, typhus and syphilis are.

Second: That like these diseases tubercle never originates spontaneously, but is perpetuated solely by the law of contagious succession.

Third: That tuberculous matter itself is (or includes) the specific matter of the disease and constitutes the material by which phthisis is propagated from one person to another, and disseminated throughout society.

Fourth: That the deposits of this matter are, therefore, of the nature of an eruption and bear the same relation to the disease, phthisis, as the yellow matter (the stools) to typhoid fever.

Fifth: That by the destruction of this matter, on its issue from the body by means of proper chemicals or otherwise, seconded by good sanitary conditions, there is reason to hope that we may eventually, and possibly at no very distant time, rid ourselves entirely of this fatal scourge.

On April 10, 1882, Robert Koch published in Berlin his most important discovery of the existence and the pathogenesis of tubercle bacillus, since which time there has been neither confusion nor uncertainty as to the practical question of the infectiousness of tuberculosis, or as to the media by which such infection is carried on. The medical profession styles itself, and properly, a learned profession, and the American people considers itself one of the most enlightened of the civilized peoples of the world; yet, although

nearly a decade has elapsed since the demonstration of the specific and infectious character of tuberculosis, I am not aware of the first movement being made on the part of any organized association of medical men, or on the part of any board of health, municipal or state, to put in operation the first practical measure towards the carrying into effect of the simple precautions announced nearly a quarter of a century ago.

To the writer it is hard to explain this indifference which looks amazingly like profound ignorance. That the question is eminently a practical one, will require but a few moments' scanning of undisputed statistics to demonstrate.

Our last census shows us that nearly one hundred thousand people die yearly from tuberculosis. It is a well-known fact that of all the diseases with which the medical profession have to contend, which ultimately result in loss of life, tuberculosis is one of the most chronic, and it is probably a safe estimate to assume that the period of incapacity for productive labor in each of the foregoing decedents was at least ten years. What does this annual loss mean in diminished productive labor? It simply means that every year there is a loss to this country by this disease alone of the labor of 1,000,000 of people for one year.

Let us now endeavor to put a pecuniary value upon this lost energy. Place the individuals earning at a low and safe figure — $200 per year. We find that we are paying a tax, levied and collected by a foreign power, of $200,000,000 per year, and, think of it, we used to be proud of the saying of our forefathers, "Millions for defense, but not one cent for tribute." In making this attempted estimate, no allowance is made for the loss from productive industry of those engaged in the nursing of the sick; nor for the sums expended for medicines, medical appliances, or for professional attention and other expenses incidental to the forlorn hope of bringing relief to the suffering. Will we not be entirely within bounds in estimating that these items will double our original sum, and that we will have an annual tribute levied upon us by tuberculosis at the sum of $400,000,000? Let us see if we cannot further illustrate the annual cost of tuberculosis by reference to the destruction of life and property by war. The Austria-Prussian war of 1866 cost in human life, 51,000 men, and $100,000,000. The Franco-German war of 1870-71 cost 311,000 men and $1,580,000,000. The war of the Rebellion from 1861-65 cost the north 280,000 men and $6,500,000,000. The annual death-rate of comsumptives each year

will be seen to be greater by far than the death-rate during the war of the Rebellion, and the annual cost larger than the yearly expense of the armies and navies of the Empires of Russia, Great Britain and Germany. Students of sanitary science know very well that this is only one-third of the picture; that the death-rate and the expense-rate due to tuberculosis is more than doubled by the other zymotic preventable diseases.

It would seem that the time had fully come when the medical profession should arouse itself to the important practical question of "What shall be done to prevent this terrible waste of life and productive energy?" Is it not high time that the alarm should be sounded, and that the voice of alarm should never be still until the public torpor and public indifference be overcome and suitable measures be put into operation, measures which are exceedingly simple and which in no degree rest upon hypothetical or theoretical foundations?

Should this question ever be seriously undertaken, it will at once appear that boards of health must be organized and raised to the highest possible point of efficiency; that such boards of health must be found in every municipality, in every state, and more important than any other, at the seat of the general government, and that the question cannot be considered with thorough efficiency until such boards of health are not only national but international. Our citizens willingly consent to be taxed for the maintenance of schools, for the training of soldiers and sailors to defend our homes against the destruction of war. Have we not an equal right and a greater reason to tax ourselves to maintain a National Board of Health, which board shall have for its object the defense of the otherwise defenseless, against the incursion of tuberculosis and other preventable diseases?

433 Franklin Street.

Dr. J. B. Mattison (*Northwestern Lancet*) states that cocaine has proved fatal in smaller dose than morphia. From the analysis of a large number of cases he concludes that the fatal dose of cocaine is uncertain, dangerous, and even deadly results following doses usually deemed safe. The age or condition of the patient appears to have no constant relation to the development of poisonous effects, but the danger is decidedly greatest when the drug is given under the skin and in persons with renal or cardiac weakness.

OINTMENTS AND PASTES.

A CLINICAL LECTURE DELIVERED AT THE FITCH DISPENSARY.

BY ERNEST WENDE, M. D., B. S.

Clinical Professor of Dermatology, University of Buffalo.

GENTLEMEN—Allow me, in a passing way, to call your attention to ointments and pastes, those preparations which we so frequently prescribe. The end and aim of all preliminary study of skin diseases, the treatment pursued, has been greatly modified. France no longer resorts exclusively to bitters and sulphur, England no longer to purgatives and various forms of mercury, tortured by ingenuity, and even America has lost faith in sarsaparilla, her once approved and universal specific.

The words of Dante, written over the gateway of hell, "Leave hope behind, all ye who enter here," were first erased from the propylon of the dermatological clinic at Vienna. It was notably Hebra who objected to the orthodox mode, and found that the skin, like other organs, may be idiopathically diseased.

Thus a careful selection of local remedies is generally recognized to promote therapeutic success in the treatment of cutaneous affections. Experience has shown that such a choice is of greater significance than a well directed constitutional administration of drugs.

Ointments, which are fatty mixtures of medicinal agents, constitute the usual and by far the most useful means for topical application. We have chiefly entering into the composition of their bases some unctuous substance, as lard, beef, or mutton suet, a fixed oil, with more or less wax, or some ingredient like glycerine, vaseline or paraffine having a similar consistence, and lastly, lanoline, a product prepared from sheeps' wool by a process of centrifugation.

The following properties are essential for a good ointment basis:

I. *Proper Consistency.*—It must be soft, smooth and pliable, readily admitting of a uniform application.

II. *Homogeneity.*—It must be homogeneous, perfectly free from grittiness or irritating bodies, hard and crystalline.

III. *Durability.*—It must *not* show a tendency to change its physical and chemical peculiarities on exposure or long keeping.

IV. *Miscibility.* It must be capable of easily receiving the medicating ingredients to be combined or incorporated, in order to facilitate their absorption and action.

V. *Power of Imbibition.*—It must be capable of absorbing liquids, especially water, the importance of which can be best realized when a salt requires solution before being incorporated, as the iodide of potassium, etc.

VI. *Limitation of Temperature.*—It must have a melting point somewhat higher than the temperature of the body. It may soften and become pliable, but must not liquify.

VII. *Inability to Produce Irritation.*—It must be perfectly bland and neutral in reaction.

Adeps or Lard is the purified fat taken from the abdominal cavity of the hog, its specific gravity being about 0.935, its melting point 95° F., and it is readily soluble in ether, benzine and the disulphide of carbon. We will find that lard, after long preservation, on exposure to the light and air, especially a damp atmosphere, is apt to become rancid. It absorbs oxygen freely, and is readily subjected to decomposition, forming glycerine and volatile acids. Besides, when under the influence of water in compounding ointments, rancidity is easily acquired. The aquisition of an acid reaction, no matter how slight, often increases the irritation of the diseased parts, which complicates the reparative process and retards recovery. Again, the affinity of lard for water is but trifling, and it assists but sparingly in the absorption of remedies by the skin. In fact, it is only fit for pharmaceutical purposes when fresh.

Vaseline or petroleum fats are substances prepared from the waste products of petroleum distillation, having a melting point which varies from 104° to 125° F.

They are insoluble in water, sparingly so in alcohol, and quite soluble in ether, chloroform, disulphide of carbon, oil of turpentine, benzine, benzol, and in fixed and volatile oils. Vaseline and its allied class have the great advantage of being durable and not prone to turn rancid, while the disadvantages are their incompatibility with water, their inferior penetrating powers, and their capability, in a few instances, where the skin is delicate and sensitive, of producing irritation.

Suet, spermaceti, wax, cacao-butter and paraffine, are too hard on the one hand, while glycerine and the fixed oils are too soft on the other, in themselves to form a good ointment basis. They are simply and occasionally used as ingredients, the former to impart firmness, and the latter pliability.

Lanoline or wool-fat being a cholesterine fat, a true product of

keratinous tissues, it is but natural to expect it to possess those qualities absolutely necessary for an excellent ointment basis. As a derivative from sheeps' wool, it was brought to notice by Prof. Liebreich, of the University of Berlin.

It possesses a specific gravity of about 0.935, while its melting point fluctuates between 100.4° and 104° F. It is soluble in ether, benzol, benzine, chloroform and disulphide or carbon, slightly in strong alcohol and insoluble in water.

It is unoxidizable, non-irritant and neutral in reaction. It is readily absorbed and retained by the skin, increasing the therapeutic action of the drugs incorporated. It will readily imbibe more than its own weight of an aqueous solution without losing its pliability or salve-like form. It adheres better to a moist surface than any other fat or oil. It facilitates union with glycerine, and is easily miscible with all other fats and oils. It is germ-tight, irreducible and hermatically sealed to microörganisms.

Moreover, its shortcomings are few and not grave, being merely charged of having a consistency slightly sticky, and a faint, sheep-like odor.

It occurs in the shops in two forms, one containing about twenty-five per cent. of water, the other free from it. The anhyrous lanoline, in my judgment, makes the much better preparation, for the addition of water might irritate in some instances, and whenever it becomes necessary to incorporate water or an aqueous solution it can be readily added at any time. To overcome the slight stickiness, I generally combine with it ten to twenty per cent. of vaseline.

Ointments may be considered as :

I. *Sedative*, when they counteract an inflammatory process, cool the burning and soothe the irritation. They act mostly in protecting the diseased surface from the stimulating action of the air and moisture, and comprises the simple ointments, cold cream, lanoline cream, etc.

II. *Astringent*, when they counteract a lax condition of the skin. They are also soothing in their action. They act in modifying inflammation and secretion by constricting the calibre of the capillaries and the ducts of glands. They include such substances as zinc, bismuth, lead, tannin, etc.

III. *Stimulating*, when they counteract a morbid process of the skin by setting up a new action, hastening nutritive changes, which

re-establish the normal performance of its functions. They contain such ingredients as sulphur, tar, mercury, naphthol, resorcin, etc.

IV. *Antiseptic* when they counteract infection. They act by preventing putrefaction and fermentation, inasmuch as they destroy microörganisms, restricting their growth and multiplication. They comprehend such remedies as iodoform, iodol, aristol, corrosive sublimate, carbolic acid, etc.

V. *Antiparasitic*, when they counteract the life, growth, and development of the various low forms of animal and vegetable life infesting the human epidermis. They act by producing direct impressions, which are poisonous to the parasite. Among them may be found styrax, beta-naphthol, mercury, balsam Peru, sulphur, etc.

VI. *Antipruritic*, when they counteract itching. They act in all probability, by paralyzing the peripheral nerves, inducing, locally, an anesthesia which relieves the over-excitation of the sensitive nerves, or by modifying an abnormal secretion or excretion, They include such remedies as carbolic acid, terebene, menthol, camphor, cocaine, etc.

Ointments are curative agents, their functions being to protect the diseased skin from all external irritants, and impurities from atmospheric influences and vicissitudes ; to aid in the absorption of medicaments ; to relieve by cooling and soothing the burning sensation of inflammation ; to mitigate pain ; to allay itching ; to alleviate an unusual dryness and harshness ; to astringe capillaries in serous effusions ; to loosen and remove an accumulated débris of crusts ; to resolve effusions, infiltrations, and new formations ; to render the parts aseptic and impassable to germs ; and, furthermore, to regain and preserve the integrity of the integument by stimulating nutrition.

PASTES.

Pastes, during the last few years, have been largely used in the treatment of skin affections, especially for the various types of eczema. They were first introduced to the notice of the profession by Lassar and Unna, of Germany. They are applications which resemble ointments having a firmer consistence, however, due to a powder incorporated in an unusual proportion. The substances used may be either of a mineral or vegetable origin. The minerals generally employed are tale, bolus alba, chalk, zinc oxide, calcium

and magnesium carbonate, while those taken from the vegetable world are usually starch and lycopodium.

The advantages over ointments are twofold. They not only defend the eruption from external irritation, exclude the air, preventing desiccation and oxidization, but the excretions and secretions of the diseased part are also absorbed. Furthermore, they aid adhesion, producing a fixation of medicaments.

Of these the one that has enjoyed the best reputation is that first prescribed by Oscar Lassar, and named after him. It consists of

R.—Acidi salicylici 2.00
Zinci oxidi . . . . . .
Amyli . . . . . .
Vaseline . . . . . .
Lanolini anhydr. aa 25.00
Misce. Leniter lerenda fiat pasta.

This exceedingly useful therapeutical preparation is of extensive applicability, notably in the different forms of eczema.

Ihle's paste contains resorcin in lieu of salicylic acid, the formula being—

R.—Resorcini . . . . . 2.00 to 12.00
Zinci oxidi . . . . . .
Amyli . . . . . .
Vaseline . . . . . .
Lanolini anhydr. aa 25.00

Its special indications are for employment as a reducing agent. As Unna puts it, when topically applied it acts "as a kerato-plastic agent. It makes the swollen and defective horny layer harder, thicker, and drier, so that it may again become more fit to take up fat."

A paste which we have found most soothing and bland in the treatment of infantile eczema, in modifying a simple dermatitis or in allaying irritation, is composed of—

R.—Campho-phenique 1.00
Bismuthi subnit . . . . . .
Zinci carbonatis . . . . . .
Amyli . . . . . .
Vaseline . . . . . .
Lanolini anhydr. aa 2.00

Other remedies as tar, sulphur, beta- and hydro-naphthol, and ichthyol may be advantageously combined.

Their mode of application is a matter for attention and of importance. They should be gently rubbed upon the diseased part with the fingers or an appropriate spatula, the former being used when the skin is tender. They should be well introduced in all cracks and crevices, and uniformly distributed in a moderately thick layer over the whole of the affected epidermis, in order that the physiological and therapeutical properties possessed by a paste may be justly fulfilled, namely :

The fixation of the medicaments incorporated.

The absorption of secretion and excretion of the lesion ; and the protection of the diseased integument.

Clinical Reports.

A CASE OF SYPHILODERMATA, ACCOMPANIED BY PECULIAR SYMPTOMS.

By J. HENRY DOWD, M. D., Buffalo, N. Y.

In reporting the following case, it is not my object to teach anything either as to the pathology or treatment of this dread disease, but simply to call attention to peculiar symptoms which can arise, also as to how sadly one can be mistaken by simply asking a patient, Did you ever have a hard chancre ? and, receiving a negative reply, try to form a diagnosis, prescribing what you may think appropriate treatment, only to find after a long and persistent course, no benefit has been derived ; where, by a little closer questioning, diagnosis and treatment would have been directed towards the true cause. The symptoms which I wish to call attention to are : (1) The intolerable itching ; (2) the drawing sensation over the affected parts ; and (3) the occurrence of the symptoms mostly at night. In regard to the itching, text-books on syphilis say, almost emphasizing the words, there is an absence of itching, and a practitioner of experience to whom I related this case said : " I thought that an itching skin disease always excluded syphilis." The question may arise, Cannot skin diseases accompanied by itching occur in the subject of syphilis ? Most certainly they can, as I have seen cases of scabies, urticaria, etc., in patients who had

and were treated for syphilis. But, on the other hand, could scabies, urticaria, or eczema erythematosium – many of the symptoms of this eruption, both objective and subjective, being present—be cured by the treatment given in this case?

J. T., single, consulted me for a skin eruption on the scalp, face and body, giving the following history: About the first of last July he noticed spots appearing on his forehead, face, neck and body, these being about the size of a silver five-cent piece, and very itchy. Soon those on the forehead gradually coalesced, until at present there is one patch three inches square, extending into the hair. The most distressing symptoms are the intolerable itching and drawing sensation, which always became aggravated at night, and which he describes "as though the bones were being pulled out." By close questioning I gained a further history: Has had gonorrhea and chancres several times but always treated himself, and never experiencing any bad after-effects but once, this being about six years ago, when he had four or five sores upon his penis, which he treated in a similar manner as previously, they healing readily; but in about two weeks afterwards (four weeks after last connection) he discovered a hard lump at the seat of one of the former sores, this being soon followed by swellings in the groin and spots upon the chest, which at first were bright red, but later copper colored (like a copper cent, to use his words). He now consulted a doctor, who treated him, advising him to refrain from drinking, but not saying what was the trouble. As he did not improve in the least, he stopped taking medicine and has remained in the same condition ever since, excepting after an occasional spree, the eruption would break out anew, remaining a week or so and again almost disappearing. In July last, when, after a spree it came out and has staid so, being accompanied by the symptoms above stated.

Treatment.—Of course, when the diagnosis of syphilis is sure, the treatment is the same as has been in vogue for years, but it is to the administration of the remedies I wish to call attention. The giving of mercury hypodermically has been practised for years, and of late has been the subject of much discussion in medical literature, the main objection being that abscesses frequently resulted, and which, of course, is a very distressing complication. If the injection has been given according to instructions, it is deep-seated, and often, owing to the patient's condition, is slow of healing. On the other hand, I am convinced that if a clean needle is used, and the solution free from sediment, there is no more danger of an abscess than there would be in giving an injection of morphine, or any substance used hypodermically, and this has been my

experience with fifty or sixty cases treated in the U. S. Marine Hospital, also the surgical ward of the Sisters' Hospital, all of which received from eight to twenty injections. I don't wish to infer that all cases should be treated hypodermically, but certain cases demand it and should be so treated, these being chosen according to the symptoms presented, and which I have tried to class under the following heads, which has been my guide in treating syphilis:

I. In all cases where the most rapid effect of the drug is desired.

II. When, by some unexplainable cause, mercury by the mouth disagrees with the patient.

III. When it becomes necessary to discontinue either drug for a time on account of salivation or iodism.

Under the first head can be classed: involvement of eyes, brain, bones, osteocopic or periosteal pains, ulcerations of mucous surfaces, eruptions of the face, dactylitis, etc.

Second. Where mercury, internally, causes diarrhea (which occasionally occurs by the smallest doses), pains in the abdomen, tenderness of the groins without salivation, etc.

Third. Where salivation occurs, and by stopping the mercury the iodide has to be stopped at the same time, and vice-versa. In the case just cited, the treatment was as follows:

R.—Hydrargr. chlor.corr..... gr. iii.
Ammon. chlor..... gr. jss.
Aq. qest..... ℥ss.
M.—Sig. Fifteen to twenty drops every other day.

R.—Syr. ferri. iod..... ℥j
Iod. pot..... ʒiii.
Syr. trifol. ..... ad. ℥iv.
M.—Sig. One drachm three times a day.

This treatment was continued for sixteen days, the patient being free from itching and the drawing sensation on the fifth day, and at date of writing he was discharged, his eruption having entirely disappeared. Before discharging him I put him on the pill hydrarg. prot. iod., gr. one-sixth, to be continued for four or five months.

132 Broadway.

Society Proceedings.

From American Journal of Obstetrics.

TRANSACTIONS OF THE FOURTH ANNUAL MEETING OF THE AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS.

HELD IN NEW YORK CITY, SEPTEMBER 17, 18, AND 19, 1891, AT THE ACADEMY OF MEDICINE.

(*Abstract.*)

FIRST DAY—MORNING SESSION.

THE President, Dr. A. H. WRIGHT, of Toronto, in the chair.

An address of welcome was delivered by Dr. ROBERT T. MORRIS, of New York, and the response was made by Dr. GEORGE H. ROHÉ, Vice-President, of Baltimore.

Dr. AUG. P. CLARKE, of Cambridge, Mass., read an essay on

POST-PARTUM HEMORRHAGE—ITS ETIOLOGY AND MANAGEMENT.

AFTER an exhaustive and searching review of the conditions leading to the post-partum bleeding, including uterine atony and hour-glass contraction, disproportionate growth of the uterine vessels, ectasis of the fundal vessels, uterine edema, placental abnormalities, fibroma or other morbid growths, lacerations of uterus, vagina, or vulva, etc., he discussed the treatment. Anesthesia is of incalculable benefit in lessening many of the dangers incident to parturition, being particularly useful in cases of uterine inertia dependent on the exhaustion of the system generally. In cases of advanced or serious renal affections, chloroform may be safer than ether. Pressure or support over the fundal uterine segments as the child recedes from it will aid in keeping up continuous or regular uterine contraction, and thus lessen the risk of the occurrence of severe hemorrhages. The administration of ergotin or ergotinin will assist in reëstablishing normal contraction. When used hypodermically its physiological and

therapeutical action is often speedily and permanently manifested. It is in the milder class of cases that its use will be of the most material service. In cases in which hemorrhage is profuse, intra-uterine injections will be of great advantage. In women of full or plethoric habit, cold water may be employed; in those who suffer from nervous affections water from 115° F. to 125° F. is to be preferred. Doubtless, when hemorrhage is arrested by hot water it is owing to the formation of thrombi more or less extended into the vascular tissues. The employment of cold has a reflex action,—it gives a toning effect to all the tissues, it facilitates the constriction of the muscular coat of the dilated vessels. Caffeine, used hypodermically, is of benefit. The application of some form of electricity will aid in some measure in promoting contraction of the uterine muscular fibres. In cases in which hemorrhage is anticipated, the early administration of quinine may in large measure serve to keep the hemorrhage under control. The occurrence of certain pains may lead us to anticipate post-partum hemorrhage. If the pains are acute and brisk, with abrupt endings, and followed by unusually long pauses, we may infer that there is a deficiency of nerve force. This may result in atony of the muscular structures and in failure to effect constriction of the uterus and closure of the utero-placental vessels. In cases in which hemorrhage proceeds from the lower section of the uterus or from the upper portion of the cervix, the application of iodoform wool and gauze, and of styptics or of iodine, will be of service. The author has great confidence in the employment of nitrite of amyl; it is an arterial and cardiac stimulant of the most extraordinary power. The employment of intravenous injections, and the dangers attending their use, were matters for determination in each individual case. The employment of alcoholic saline intravenous injections for their dynamic or tension effect will be most beneficial. The author's later experience favors the adoption of the method of hypodermic injection or transfusion of spirituous saline solutions. This method is more convenient, is safer, and is more likely to be followed with favorable results. Other methods for controlling hemorrhage and for preventing collapse are referred to. Compression of the abdominal aorta should sometimes be tried. This may, in some measure, enable the medical attendant to get control over the hemorrhage when all other means have failed. This procedure has been approved by such great authorities as Barnes, Churchill, and Simpson.

Dr. ROBERT T. MORRIS, of New York, read a paper on

A NEW METHOD OF PALPATING THE KIDNEY.

Dr. W. J. ASDALE, of Pittsburg, read a paper on

REMOVAL OF THE KIDNEY IN DISEASE, WITH CASES.

Before reliable conclusions and methods can be established, and this most formidable surgical procedure can be made safe, if ever, a familiar acquaintance with all that has been done in the sphere of renal surgery must be secured and the details of a considerable number of cases must be carefully studied, that questions of both physiological and pathological import may be determined. Any contribution, although stating no new facts, may be of present value by corroboration and emphasis of points previously taken.

The following points were accentuated by the histories of a number of cases and operations:

First, in respect to the symptomatology of malignant disease. It is often insidious in its attack; pain may be absent or insignificant in amount. Early copious hemorrhages, without any marked previous manifestations of concern, are most suggestive of structural change of malign character.

Second, in regard to method of operation. The choice will be governed not more by preference than by necessity. We are reminded, however, of the facility of approach by the lateral abdominal method of incision, and of the ease with which large solid growths may be taken from the renal site. Again, in all cases it is of primal importance to possess the advantage of direct palpation of the other kidney before nephrectomy; this manœuver the operation by primary anterior incision makes easy.

The antero-lateral incision provides the minimum of injury to the peritoneum and the strongest assurance that soiling of the peritoneal surface will be avoided. Drainage, the importance of which cannot be overestimated, can be most efficiently applied after the lateral abdominal operation. Shock, even to the aged and feeble, does not of necessity inure to forbid a carefully conducted operation for removal of the kidney. Finally, the importance of early diagnosis and the futility of late operations, in malignant disease especially, are clear.

DISCUSSION OF THE TWO PRECEDING PAPERS.

Dr. A. Vander Veer, of Albany: We owe Dr. Asdale our thanks and gratitude for his thorough and candid manner of reporting his cases; there was a fatality present that no operator can avoid—that is, an advanced condition of disease. Malignant disease of itself is always a dangerous condition for us to attack, and when advanced, as in these two cases, we have heavy odds against us. The consensus of opinion is that chloroform is the safest anesthetic to use in surgical kidney. In malignant disease let us operate early,—as early as possible.

Dr. C. A. L. Reed, of Cincinnati: The question of the treatment of the pedicle in nephrectomy will remain a serious one as long as we have kidneys to remove. We all recognize the treach, erous friability of the renal vein. To avoid the unhappy and almost necessarily fatal accident of cutting it by a tight ligature he had put around this vessel the protecting influence of its neighboring structures, and had ligated the pedicle in one mass. He endeavored, in effecting the division, to leave something of a button to make the ligature secure. So far he had not been embarrassed with secondary hemorrhage. The amount of force that is required to control hemorrhage from the renal artery need not be so great as to cut the walls of the neighboring vein, providing we have left a sufficient button to prevent slipping of the pedicle under the very considerable circulatory pressure which is brought to bear upon it, during the few hours immediately succeeding the operation. Unless there be surgical conditions of the ureter itself demanding special treatment, there is no need of treating it other wise than you would the circulatory vessels.

Dr. Kellogg, of Battle Creek, Mich.: The question which should be raised in this discussion is, whether it is better to remove the kidney, or whether it is better to perform the operation of nephrotomy. If we drain the kidney in case of suppurating kidney and in case of malignant disease of the kidney, the patient will likely recover. Mr. Tait never removes the kidney. If any operation at all was considered desirable, he performed the operation of nephrotomy through the lumbar region and drained the kidney. K. made it a practice to examine the position of the kidneys and all abdominal organs in every case of pelvic disease of women. In a very large proportion of cases the right kidney especially is prolapsed and movable. In thirty per cent. of all cases in which

there is displacement of the pelvic organs, there is also displacement of the kidneys. His method has been to first examine the patient on the back, the shoulders elevated, and legs flexed forward so as to relax the abdominal muscles as much as possible; placing one hand at the back and the other hand in front. In case he fails, he has the patient rise on the feet and rest against the end of the table; then, on bending forward, the abdominal muscles are completely relaxed, the kidney is dragged down, and when the patient takes a deep breath it is easy to seize it, if it is at all prolapsed.

Dr. J. H. Carstens, of Detroit: I am much interested in the diagnostic points made. In all diseases of the kidney there is great danger in using ether. In all such cases it is advisable to use chloroform. Looking back upon cases which have died within twenty-four to forty-eight hours, reported dead from shock, I am confident now that they died from the ether. Even chloroform will produce congestion of the kidney, but not to the extent ether does.

Dr. Henry T. Machell, of Toronto, asked for points which would enable us to recognize the kidney after the abdomen is opened. He had seen in more than one instance a considerable loss of time in recognizing and determining what was or what was not the kidney.

Dr. Morris, of New York, said that as to the question of how we can determine whether we have kidney or some other organ, he had only once been in the position where he could not tell from the character of the capsule and the tissue of the organ whether he had kidney, liver, some morbid growth, or some other organ. In that case he had colloid carcinoma; he found the aorta, then the renal artery and traced that, and determined from the relative position of the renal artery that the kidney was beneath this mass.

Dr. L. S. McMurtry, of Louisville, read a paper on

INTRAUTERINE IRRIGATION AFTER LABOR.

The author referred to the relation of microörganisms to septic infection during the puerperal state, and insisted upon the application of aseptic methods in the lying-in room. He also referred to the fact that even modern treatises on midwifery were inexplicit in giving directions with reference to the essential methods of prophylaxis, and that they failed to lay down definite lines

of treatment for the initial stage of puerperal sepsis. He further insisted that these cases should be dealt with promptly at the very outset by systematic employment of intra-uterine irrigation after labor, which should be done with all the care of an important surgical procedure. He also stated that the danger which had been attributed to this method was not a real one, if the lines laid down for its employment were carried out with exactitude. He insisted that the operation should be performed by the surgeon in person, and that antiseptic agents were not essential, provided an absolute cleanliness was maintained, and that irrigation was carried on to the extent of removing all the débris and decomposing material which lodged in the uterine cavity.

The author employs for this purpose a fountain syringe, provided with a glass nozzle, and loaded with clean water, that has been previously boiled. It must be used quite warm and the patient's clothing must be drawn out of the way, while the extremities are to be protected with blankets. A free exit for the return flow must be provided. When this is done in a careful way with water at the proper temperature, the patient's comfort is enhanced, and her improvement, as a rule, is immediate. The principle of treatment is that of flushing and drainage, the efficiency of which has been demonstrated in similar conditions in pelvic surgery.

Dr. W. W. Potter, of Buffalo: The distinguished Fellow from Kentucky sounded the keynote of this whole question of intra-uterine irrigation after labor, when he said that the time for commencement of the treatment was at the time when it became essential—that is, at the initial symptoms of infection. If we could only always determine when the initial symptoms presented, I have no doubt that this method would result in the saving of life and in the prevention of prolonged sickness. There are ways in which infection gets to the vital organism insidiously, which we only recognize by watching the symptoms which it produces; hence the importance attaching to the careful watching of the puerperal woman by her attendant,—not treating a labor case lightly, not going to it and hurrying away in a few minutes after delivery, and saying "I will come back when you need me,"— but she is to be watched with all care, even after simple labor, for a few days, until all danger of the infective invasion has passed away. It is important to emphasize all this, for the obstetricians of today must certainly recognize the fact that they are occupying a more respon-

sible place than ever. There is more light upon the subject than formerly.

Dr. E. E. Montgomery, of Philadelphia: This subject is one of vital interest, for upon the meeting and subduing of the germs at an early stage is dependent the future comfort, health, and possibly life of the individual. He fully indorsed what was said as to the importance of early intrauterine irrigation where there is the least indication of septic infection. We have in the cavity of the uterus a large absorbing surface; a surface that is covered with débris, a surface in which, through the heat of the body and the character of the secretions, germs multiply with great rapidity, are readily taken up and carried through the vessels, carried by the continuous action of the mucous membrane into the tubes, and we have secondary infection not only of tubes and ovaries, but we have systemic infection through the absorption into the system. It is important to render this surface sterile early and prevent the development of the disease. In such cases he would advocate, in addition to irrigation, the use of the curette, the scraping away and removal of the infected débris, and, after irrigation with a chemical solution, the introduction of a twist of gauze to the fundus, and in this way make sure that the subsequent drainage was perfect and complete.

Dr. Geo. H. Rohé, of Baltimore: It is my conviction, based upon observation and some personal experience, that the practitioner who is in doubt about antisepticism in obstetrics will lose nearly as many patients from septic troubles as one who disbelieves in that method. If there is any one thing necessary in practising aseptic obstetrics, it is a firm belief that it is absolutely necessary in every case. Consequently it has been well said that the time to begin treating sepsis in a lying-in woman is before she is septic. But even after the septic condition has been established, a thorough carrying out of the antiseptic practice will result in success in a large majority of cases. Any one who has ever seen the interior of the uterus of a woman who has died of septic infection after delivery, will appreciate the importance of more than superficial measures,—not merely an injection now and then, even thoroughly made, but also the use of some chemical disinfectant which will inhibit the rapid multiplication of the germs.

Dr. J. H. Carstens, of Detroit: It has been pretty well settled that normal cases had better be let alone; but where symptoms

develop, it is well to start irrigation very early. There are cases where the temperature rises up to 103°, or 104°, or 105°, where the irrigation has no effect at all, even if you irrigate every three hours, or two hours, or every hour. There is no débris there; nothing wrong with the uterus; the physician or midwife who attended the wound was aseptic, and still that woman has puerperal fever. These are cases of auto-infection. We know that when women have a latent disease of the tubes, be it tubercular, gonorrheal, or an ordinary pyosalpinx, the act of parturition will cause it to break out in full force or will cause a rupture of the tube, which will allow pus to run down into the uterus and there set up a violent sepsis. These are the cases which need laparatomy. We ought to have it before our minds that there are cases which are due to a poison being introduced from without, by the physician or nurse, and there are other cases where the cause is within the patient and may have been lying latent for years, simply needing something to cause the explosion.

Dr. Cushing, of Boston, in confirmation of what the last speaker said, reported a case that apparently sprang from tubal infection.

Dr. A. H. Wright, of Toronto: I indorse the statements expressed in the paper. The subject is of the utmost importance. Nothing in the art of obstetrics has given me more anxious thought than this question of antisepsis. It is my practice in the lying-in hospital and in private practice to use intrauterine irrigation very seldom. In itself it is an evil, capable of doing a certain amount of harm. When the necessity arises I certainly do not scruple at once to go on with irrigation in the interior of the uterus. As far as I have seen irrigation carried on by general practitioners, I have been sometimes rather horrified at the miserably careless and indifferent way in which it was done. It is a very difficult thing to teach hospital students how to do this properly.

Dr. J. F. W. Ross, of Toronto: I do not think ordinary water used as an injection is as good as some antiseptic solution. My experience with intrauterine irrigation has not been as favorable as I could wish. Two cases of puerperal septic trouble coming under my notice within the last two years have been treated by packing the uterine cavity with iodoform gauze through a speculum, and in this way attempting to subdue the formation of the poisonous ptomaines in the cavity.

Dr. KELLOGG, of Battle Creek, said there was another use for irrigation which had not been mentioned. In a case in which the temperature rose to 104½°, irrigation was employed, but did no good. By the application of a hot douche, 140°, the uterus was made to contract. The next morning the temperature was normal, and did not rise again. His plan of using the douche is to introduce a large drainage-tube, then a small catheter through the drainage tube, and then to use water at a temperature of 130°. Lower temperature is often the reason for failure. Warm water relaxes, hot water contracts. Very hot water is efficient as a germicide. The uterus will bear a still higher temperature.

Dr. MCMURTRY, closing the discussion: I feel very grateful to the Fellows for the very cordial manner in which they have received the suggestions I intended to convey. The purpose of the paper was not to discuss the routine use of intrauterine irrigation after labor, or to deal with the prophylaxis of puerperal sepsis, but simply to emphasize the point that this very valuable method, which we can institute in the very initial stages of sepsis, is not generally appreciated by the great body of the profession; that the golden moment when it can be most efficient is lost by the administration of a hypodermic dose of morphia, or other tentative measures, under the mistaken idea that the initial stage of sepsis is a little milk fever or malaria, or some little disturbance brought on by the process of labor. Dr. Carstens, of Detroit, has alluded to a class of cases which should not be considered in connection with this treatment at all—that is, to the fulminating cases, cases of sapremia, where in a few hours the system is thoroughly saturated with the poison; cases that nothing in the world can resist. Even in the initial stages of these cases this treatment can do no harm. The cases alluded to by Dr. Cushing are scarcely within the scope of the discussion. There is no such thing as auto-infection of a woman after labor. Cases of tubal disease belong to that class where the disease was present before labor began. They may have been mechanically affected by the process of labor and the muscular contractions, so as to complicate the case. They are complications of the puerperal condition. Moreover, the treatment of those cases by laparatomy, evacuation, removal of the disintegrating structures, drainage, and irrigation, is but an application from above of the same principle of treatment.

First Day—Afternoon Session.

Dr. Llewellyn Eliot, of Washington, D. C., read a paper,

Is a child viable at six and a half months?

He referred to the French law, which excludes the possibility of the viability of a child born before the sixth month (one hundred and eighty days), as unjust, since cases have occurred where children born before that time have been reared and lived for many years. He denied the plea of superfetation, in these cases, as untenable. A table comprising cases in which the period of utero-gestation extended from the fourth month, (one hundred and twenty days) to the termination of the seventh month, supplements the paper. Dr. Eliot related the histories of three cases of early viability, one at six months and eleven days, one at seven months and one day, and one at seven and a half months, and drew the following conclusions: 1. A child under peculiar circumstances of development is viable at four months. 2. A child is viable at six and a half months. 3. The moral character of the parents has nothing to do with the birth of a premature child, when considered from a standpoint of constitutional development. 4. Obstetricians should strive to convince jurists of these facts.

Discussion.

Dr. H. O. Marcy, of Boston, reported the case of a syphilitic woman with a healthy husband. Both desired children, but she had aborted eight times. He had attended her two or three times in abortion at the fourth or fifth month. In her last pregnancy at about the fourth month she had slight indications of abortion. At about the sixth month she aborted. The fetus was living and was at once placed in an incubator. It is now a strong young boy.

Dr. J. H. Carstens, of Detroit: The paper of Dr. Eliot is one of great importance from a medico-legal standpoint. I would hesitate to say that a child was five and a half or six months, or six and a half months. I do not see how it is possible for us to say how long a child has been in utero. A woman may have a discharge of blood similar to menstruation when she is already pregnant for a month. In the present state of our knowledge it is

clearly impossible to say how old that child is, unless you have two absolute factors: that you have the woman menstruate at a certain date, and that coition was had only at one certain date. You cannot even judge from the time the woman feels life, because that varies.

Dr. Eliot, of Washington, D. C., closing the discussion, said that in using the incubator it was necessary to regulate the amount of moisture as well as heat. If we have it too dry, we kill the child; if we have it too hot, we kill the child.

Dr. E. E. Montgomery, of Philadelphia, read a paper on

THE APPLICATION OF SACRAL RESECTION TO GYNECOLOGICAL WORK,

in which he advocated the procedure in all cases in which uterus and rectum were both involved with malignant disease, and in cases of uterine cancer, where the uterus was enlarged or where the vagina was small and the case complicated by disease of tubes and ovaries, causing extensive adhesions.

He places the patient upon the left side or semi-prone position, and makes a bow-shaped incision from the right sacro-iliac synchrondrosis across the median line to a little beyond the apex of the coccyx, enucleates the latter bone, separates ligaments and muscles from the right side of the sacrum, and, beginning just below the third posterior sacral foramen, cuts off with chain saw or bone-pliers the right ala of the sacrum.

In operations for removal of the uterus and its appendages, the rectum is pushed to the left and the peritoneum opened. This brings the operator upon the posterior surface of the uterus, when the broad ligaments may be seized by hemostats, raised up, the broad ligaments ligated, and the uterus removed. After removal of the organ, the peritoneal surfaces may be stitched over the vagina and the posterior peritoneal opening also closed. He does not prefer it to vaginal hysterectomy where conditions are favorable for the latter. He reported two cases in which he had done the operation; one for cancer of the rectum and uterus, in which three inches of the rectum and the uterus and appendages were removed and the calibre of the gut restored. A large collection of feces pushed up the lower segment of the rectum, requiring the wound to be reopened and a secondary operation four weeks later. The second operation was done for cancer of the uterus,

complicated by tubal and ovarian disease with adhesions. Both patients recovered, and no inconvenience in locomotion was experienced.

Dr. C. A. L. Reed, of Cincinnati: This operation attracted my attention when the first publication of it appeared. Like many of the other operations, particularly those that involve the invasion of structures that we have not been in the habit of treating surgically, it appears to be more formidable than perhaps it really is. In an effort to treat malignant disease involving the middle segment of the rectum, this operation would be demanded and would be justifiable, for we are justified, perhaps, in doing almost anything for the relief of malignant cases, particularly those involving important tissues, such as the rectum and uterus; but if we can bring the maximum of relief with the minimum of risk, that is the line that we ought to follow. There is one question which cannot be answered as yet from any ascertained results, and that is with reference to the remote influence of this operation. The removal of the coccyx and the removal of the lower segments of the sacrum, must of necessity deprive the lower portion of the pelvis of an important basis of support; and what is the condition of our patients with regard to the support of the superimposed viscera following the operation, after a considerable length of time? Dr. Montgomery's cases are yet too recent to afford an answer to this question. While the primary results have been very good, it would have been vastly better to have relieved his patient by primary colotomy; but if this operation will bring the same amount of relief with as little risk of primary mortality, and at the same time insure the patient voluntary control of her fecal discharge, by all manner of means let us encourage it.

Dr. H. O. Marcy, of Boston: We ought to lay emphasis upon primary colotomy. I mention it simply because I lost two patients where the result might have been entirely different if I had done colotomy first. This was in cancer of the rectum. When we recollect that the intestine is very fully distended with gases and feces, the pressure upon our sutures is something enormous. Primary colotomy gives us that all-important factor of surgical rest of the tissues with a far better promise of success.

Dr. H. T. Hanks, of New York, thought that this operation could be recommended in most cases of chronic pelvic abscess where a rupture has taken place into either the vagina or rectum,

and where the tissue underneath the broad ligament is honeycombed. He was interested from the fact that he had had one or two cases where he probably would have succeeded better by doing this operation. It is a difficult matter to cut through the abdominal wall into the true pelvis and find out the exact condition. Though we very quickly get a view of the parts, we cannot manipulate easily.

Dr. W. H. Wathen, of Louisville, congratulated Dr. Montgomery upon his courage, his tact, and his excellent technique.

Dr. A. Vander Veer, of Albany: I would not be willing to abandon vaginal hysterectomy for removal of the uterus and ovaries. The technique of vaginal hysterectomy is so perfect, it is one of the most brilliant operations we have to perform at the present time, and the results are satisfactory. In regard to colotomy, I never had a patient who was thoroughly satisfied with the result of the operation. All were dissatisfied with the fecal discharge. But in the five or six cases in which I have operated for removal of the lower segment of the rectum, it mattered not if there was some leakage, some trouble in keeping a pad there and receiving the feces; they all say, "Doctor, it comes out at the right place. It feels more natural."

Dr. Ap Morgan Vance, of Louisville: The performance of primary colotomy would bring about a difficulty from the fact that a good deal of the gut was to be removed: and if there is cancer there, the more removed the better. If it was tied, anchored, at the point of ordinary colotomy, we would have difficulty in bringing it down to get approximation.

Dr. J. F. W. Ross, of Toronto, read a paper entitled

HOW SHOULD WE PROCEED WHEN ABDOMINAL TUMORS ARE COMPLICATED BY PREGNANCY?

He emphasized the point that there was nothing of malpractice in the opening of an abdomen during the existence of a concealed pregnancy, before proceeding to discuss cases in which pregnancy has been recognized. Cases of ovarian tumor and fibroid tumor of the uterus were reported, and a request was made for reports from members of the association, so that a foundation might be laid on which to build up a few fixed rules for future guidance. Ovarian

and myomatous tumors were the only two forms taken into consideration.

Ovarian Tumors.—He said that the methods of treatment to be discussed were :

1. To allow the pregnancy to go to full term, or until the uterus throws off its product.
2. Puncture of the cyst until delivery is completed.
3. Induction of premature labor.
4. Ovariotomy—the uterus left to abort or go to term.
5. Ovariotomy—the uterus emptied of its contents by incision.
6. Ovariotomy and abdominal hysterectomy.

The author advocated early ovariotomy, but supported cyst puncture in certain favorable cases, if the patients objected to other operation or wished to have a living child. If at any time bad symptoms arose, he insisted on immediate abdominal section.

In advanced cases, where injury or much handling of the uterus is unavoidable, the organ should be emptied to forestall the almost inevitable abortion or premature labor.

Myomatous Tumors.—1. Induction of premature labor.
2. Early myomotomy or abdominal hysterectomy.
3. Late hysterectomy or Cesarean section.
4. Tentative measures, as :
   (*a*) Enucleation of cervical tumor to permit labor completion.
   (*b*) Enucleation of a sloughing tumor following labor.
   (*c*) Abdominal hysterectomy for a sloughing tumor or uncontrollable hemorrhage following labor.
   (*d*) Abdominal hysterectomy for septic infection from retention of discharges in the non-contractile uterus.
   (*e*) Abdominal hysterectomy or Cesarean section to end a labor that will require long forceps, version, or craniotomy.

He finally concluded that the tentative measures were the best.

Dr. H. T. Hanks, of New York : I have been interested for many years in the subject of uterine and ovarian tumors. We not only want to consider the patient but the surroundings, and when you know that you have got a unilocular cyst, that you can tap and remove the fluid and the patient can go on to term, or at least to eight and a half months, you are justified in doing it. But if the pregnancy is complicated with fibroid tumors, the case is dif-

ferent. They grow very rapidly from the first month up to the fifth or sixth month, but do not from the seventh to the ninth month. If the tumor is situated in the cervix you should enucleate it, because you cannot deliver through a cervix of which two-thirds is a fibroid. If you cannot do that, you are justified in producing premature labor or an abortion at the second or third month. If the tumor is the size of your fist, and you can push the cervix above the brim, and you have two-thirds of the cervical tissue healthy, you are justified in delaying. If the tumor is above the middle zone the child can be delivered quite easily at term.

Dr. A. Vander Veer, of Albany: The difficulty of diagnosis in a case of fibroid of the uterus or ovarian tumor is one of the problems of surgery. The subject is now being handled with much greater clearness and more satisfaction, but it is essential to make a diagnosis, and in making the diagnosis we have very little that helps us in the history given by the patient. A condition which Dr. Ross did not touch upon is this, that in most cases where a patient who has a uterine fibroid becomes pregnant, the tumor will take on a certain amount of growth,—more in some cases than others. Occasionally it undergoes a sarcomatous change. Again, a patient may have a fibroid, go through pregnancy and a safe delivery, after which the fibroid will disappear. The medico-legal point of this question has been touched upon by two or three of the decisions that have occurred in court. We should be thoroughly united and thorough in our emphasis that in these cases the fibroid does sometimes disappear under the influence of pregnancy. In the treatment of ovarian tumors coincident with late pregnancy, we should tap and carry the patient along as near as possible to the full time.

Dr. I. H. Cameron, of Toronto: I am strongly in accord with the opinions expressed that no general rules can be laid down for our guidance in any case. Every case, as Dr. Hanks has said, must be treated on its own merits. A sharp distinction should be made between tumors involving the uterus and those involving the ovaries. As has been said, the position of fibroid tumor makes all the difference in the world. If it be clear that from the position of the tumor it will not interfere with delivery, it may be laid down as a general rule that it should not be touched before gestation is complete. Of course, there may be risks of inflammation or malignant disintegration. I would like to enter my protest

against tapping a unilocular cyst as a palliative measure. Twice in the last week I have had occasion to witness the very great danger of tapping.

Dr. H. O. Marcy, of Boston, said that he agreed with Dr. Cameron. He supposed tapping under these circumstances was out of the question. He reported a case showing its danger.

Dr. W. W. Potter, of Buffalo, reported a case of successful operation for removal of a tumor during pregnancy.

Dr. H. O. Marcy, of Boston, asked what was the condition of the veins.

Dr. Potter replied that they were highly congested. He believed that it was a case where tapping would have been very bad practice. His experience and that of others led him to believe that tapping should never be employed; if anything was done, it should be through an incision.

Dr. J. H. Carstens, of Detroit: I am inclined to think that because of the peculiar blood changes, union takes place better during pregnancy than at any other time. I wish emphatically to protest against the tapping of tumors during pregnancy. Cases of ovarian tumor, no matter what kind they might be, occurring during pregnancy, ought to be operated upon. In case of fibroid, you have to judge of each individual case yourself.

Dr. A. Vander Veer, of Albany, said he did not suppose there was any man in the State of New York who had in his teachings emphasized more this point in reference to tapping in the case of an ovarian tumor than he.

[*To be continued.*]

Dr. Philip S. Wales, U. S. N., Medical Director National Museum of Hygiene of Washington, recommended to Lieut. Perry, the Arctic navigator, that the underwear of the exploring party should be so constructed as to prevent radiation, and also encircle the body with a stationary atmosphere. The theories for clothing of Profs. Von Petten Koffer, Director Hygienic Institute, Munich, and Parkes of London, have also a bearing on the above and they are conceded to be embodied in the Jaros Hygienic Underwear. The excellent results with an extra heavy fabric of these garments in the United States Army North Posts, have made it possible to successfully withstand a temperature of forty-seven degrees below zero and in a thirty mile ride without buffalo coat.—*The Prescription.*

Progress in Medical Science.

PHYSIOLOGICAL CHEMISTRY.

CONDUCTED BY

JOHN A MILLER, Ph. D. (BERLIN).

TUBERCULIN.

W. HUNTER (*Brit. Med. Jour.*, ii., 1891; *Jour. Chem. Soc.*, 60, 1283,) subjected Koch's tuberculin to an approximate analysis with the following results. In order of importance and amount, the substances present are:

1. Albumoses; chiefly proto-albumose and deutero albumose, along with hetero-albumose, and occasionally a trace of dysalbumose.

2. Alkaloidal substances, two of which can be obtained in the form of platino-chlorides.

3. Extractives, small in quantity and of unrecognized nature.

4. Mucin.

5. Inorganic salts.

6. Glycerol and coloring matter.

Serum albumin, globulin, and peptone are absent.

With regard to its action, the following conclusions are drawn:

1. Tuberculin owes its activity to at least three, and probably more, different substances.

2. Its remedial and inflammatory actions are connected with presence of certain of its albumoses, while its fever-producing properties are chiefly associated with substances of a non albuminous nature.

3. The albuminoses are not lost by dialysis; the latter are. It is thus possible to remove the substances which produce fever, while retaining those which are beneficial in their action. The fever is thus not essential to its remedial action, and the same may probably be said for the inflammation, although, under certain conditions, inflammation appears to be beneficial.

4. The remedial action consists in shrinking of the tuberculous tissues, and increased sealing, due to deep local congestions.

5. The remedial substance resists high temperatures. Its action is, however, lessened by a dry heat of 70°. Its properties

are materially altered by changes occurring during its purification by dialysis, and thus its preparation is attended with difficulty.

6. The remedial substance and the other albumoses present are stated to belong to the class of "proteins," that is, albuminous substances derived from the protoplasm of the bacilli themselves, and not merely formed by the action of these bacilli on the surrounding tissues.

HUMAN RESPIRATION, AIR BEING REBREATHED IN A CLOSED VESSEL.

W. Marcet (*Proc. Roy. Soc.*, 49, 103 ; *Jour. Chem. Soc.*, 60, 1270). The results obtained in the present inquiry are, viz. :

1. On rebreathing air in a closed vessel, less carbon dioxide is expired within a given time than in ordinary breathing, the volume of the air undergoing at the same time a slight reduction.

2. When fresh air is taken after rebreathing air in a closed vessel, the volumes of air breathed and the weights of carbon dioxide expired are greater than in ordinary breathing; this, however, passes off in a few minutes.

ACTION OF PARAFFINIC NITRITES ON BLOOD PRESSURE.

J. T. Cash and W. R. Dunstan (*Proc. Roy. Soc.*, 49, 314 ; *Jour. Chem. Soc.*, 60, 1270). A broad summary of the action of the nitrites is as follows :

All produce a fall of blood pressure, and an accompanying acceleration of the pulse ; the latter is not so marked after intravascular injection as after inhalation, and is also less marked in cats than in men. The respiration is affected temporarily during inhalation in various degrees by the different nitrites, and permanently by repeated administration of the same or different nitrites.

The activity of the nitrites, as measured by the fall in blood pressure after inhalation is, viz. :

(1) Secondary propyl ; (2) tertiary butyl ; (3) secondary butyl ; (4) iso-butyl, nearly equal ; (5) tertiary ; (6) *a*-amyl ; (7) *b*-amyl, nearly equal ; (8) methyl ; (9) butyl ; (10) ethyl ; (11) prophyl. After intravascular injection, however, the order is nearly the reverse.

UROBILIN IN VARIOUS DISEASES.

G. HOPPE-SEYLER (*Virchow's Archiv*, 124, 30; *Jour. Chem. Soc.*, 60, 1278). The urobilin in the urine is increased by—

1. Stasis of the bile in the liver, provided bile can pass into the intestine, and diuresis occurs, as in polycholia.

2. Stagnation of the contents of the large intestine, not of the small intestine.

3. Hemorrhages into internal organs.

Approximately the normal amount is found in—

1. Pernicious anemia.

2. Leukemia and pseudoleukemia.

It is diminished in—

1. The suspension of hepatic activity that occurs in cachexia, inanition, and many forms of anemia.

2. Stasis of bile in the liver, if bile does not pass into the intestine and diuresis is produced.

3. In the course of jaundice, sometimes. The amount of fecal pigment is no gauge of the amount of urobilin in the urine.

The normal mean, of urobilin, amounts to 0.123 gram in 24 hours.

CHEMICAL CONSTITUTION AND PHYSIOLOGICAL ACTION.

T. L. BRUNTON AND J. T. CASH (*Proc. Roy. Soc.*, 49, 311; *Jour. Chem. Soc.*, 60, 1279). In continuation of former work, the present research is occupied with (1) the physiological action of benzene, and (2) the alterations which occur in its action when one or more hydrogen atoms are replaced by (*a*) haloid radicles, (*b*) alcohol radicles, (*c*) by hydroxyl, (*d*) by NO_2, and (*e*) by NH_2. The modifications produced by temperature were also noticed.

The action of benzene and its compounds is chiefly exerted on the spinal cord, although they act also on the cerebrum, and, to a slight extent, on nerves and muscle. The effect on muscle and nerve is to weaken them, the paralysing action being stronger on the nerve than on the muscle. Their action on the cerebrum is evidenced by lethargy, both in frogs and rats. There is increased excitability of the spinal cord, there being greater diffusion of stimuli with diminished power and definiteness of movement. Large doses, however, cause paralysis.

Haloid radicles do not modify the action of benzene to the same extent as they do that of ammonia, but they do so in somewhat the same direction. Monochlor-benzene affects the cord more than benzene, causing spasm and rapid diminution of reflexes. It also weakens the circulation, but does not seem to affect muscles, or motor nerves, more than benzene. The bromo — and iodo — compounds act more powerfully on the cerebrum, and the iodo-compound has a special tendency to paralyze motor nerves, muscles, cerebral reflexes, and to depress the heart. Heat accelerates and cold retards the action of the substances.

The substitution of alcohol radicles for the hydrogen in benzene has the effect which one would expect, in having a more sedative action on the nervous system. The circulation is little affected, and their action is more fleeting than is the case with the halogen compounds.

Substitution of hydrogen by hydroxyl increases the tendency to convulsions; this is due to action on the spinal cord.

Amido-benzene (aniline) produces symptoms resembling those caused by ammonia, consisting in a tendency to produce violent spasm and great paralysis of muscle and nerve. It differs from ammonia in the fact that the convulsions never assume the form of true tetanus.

Nitro-benzene causes lethargy, with increasing tremor or movement, and early abolition of reflex action.

The general action of these compounds on reflex time is to lengthen it, but a primary shortening was frequently observed in the case of chloro-benzene, slightly also in that of methyl-benzene, dimethyl-benzene, and ethyl-benzene.

In producing muscular rigor, chloro-benzene is more powerful than the bromo- and iodo- compounds, and is intermediate in effect between methyl-benzene and dimethyl-benzene. Of the methyl-benzene, the methyl- is the strongest, the dimethyl- next, and the trimethyl- weakest. Ethyl-benzene is of nearly the same strength as methyl-benzene in this respect.

In warm-blooded animals (cats), respiration is early affected, there being a primary acceleration followed by slowing. The heart stops before respiration in poisoning by benzene and its haloid compounds, by ethyl-benzene, amido-benzene, and nitro-benzene, whilst respiration ceases first in poisoning by the methyl-benzenes and hydroxy-benzenes.

The first effect of the benzene on the pulse and blood pressure

is a quickening and rise respectively. This is followed by a slowing and a falling.

ACTION OF RELATED COMPOUNDS ON ANIMALS.

W. Gibbs and E. T. Reichert (*Amer. Chem. Journ.*, 13, 289; *Jour. Chem. Soc.*, 60, 1280).

The Hydrazines. - Phenylhydrazine hydro-chloride depresses the cerebro-spinal centers, producing, in frogs, decreased sensibility and voluntary and reflex inactivity merging into unconsciousness and paralysis. Death results from respiratory and cardiac failure, and the heart stops in diastole. In the dog, it acts at once on the heart, causing a preliminary quickening of pulse and lowering of blood pressure. The hemoglobin is changed into an abnormal form, the blood becoming almost black. Temperature falls 1-2°. Respiration is at first quickened and then slowed, either by the action of the drug on the respiratory centers, or by the deficient oxygenation of the blood. The action of ortho- and paratolylhydrazine hydro-chloride is similar, but less pronounced. Fatal dose when injected into the jugular vein of a dog, is 0.12 gram of phenyl-hydrazine, or 0.2 gram of orthotolylhydrazine, per kilo. of body weight.

Tolueylenediamine produces in frogs general muscular depression, but does not appreciably affect the sensory and motor nerves. The heart stops in diastole. In dogs it causes muscular depression, lowering of temperature, salivation, darkening of the blood, and diminution of the rate of respiration. The heart stops in diastole, and the stomach and intestines are found to be congested after death. Small doses of 0.8 gram per kilo. injected intravenously, increase the pulse rate, blood pressure, and respiration rate; the variation in the last is caused by direct action on the respiratory centers. The fatal dose for dogs is 0.2 gram per kilo. when injected subcutaneously; much larger doses may be injected intravenously.

Nitrophenols. Dinitrophenol injected into the jugular vein of a dog in small doses of 0.2 gram per kilo. causes a stimulation of the vagus, proportional to the amount injected, and a rise in pulse rate and blood pressure. With large doses the heart stops before respiration ceases, and the blood pressure falls just before death. The minimum fatal dose is 0.05 gram per kilo. injected. When

given by the mouth, the respiration rate at first rises, but subsequently falls, temperature rises 2-3°, and the pulse rate first diminishes and then increases. The drug seems to act directly on the motor portion of the spinal cord. Death results from respiratory failure when the poison is slowly absorbed through the stomach, from cardiac failure, when it passes in mass into the heart. *Trinitrophenol* injected into the jugular vein of the dog stimulates the pneumogastric nerve or centers to such a degree as to cause the immediate stoppage of the heart. If the pneumogastric nerve is divided, death occurs from respiratory failure. The fatal dose is 0.06 gram per kilo.

Nitro-benzenes.— Nitro-benzene (or nitro-benzol) acts on the spinal cord, causing in the frog increase in reflex activity, decrease in voluntary activity, and successive increase and decrease in pulse and respiration rates. The color of the blood is changed to chocolate, the hemoglobin being converted into nitrite-hemoglobin. In the dog, when administered by the mouth, it produces salivation, unsteadiness of gait, rise of temperature and pulse rate, weakness, and unconsciousness; the respiration is quickened by a direct action on the respiratory centers. The animal may recover if the dose does not exceed 0.75 gram per kilo. When injected into the jugular vein, in which case the fatal dose is 0.15 gram per kilo., the blood pressure is diminished by the depression of the heart muscles and vaso-motor centers. The action of dinitro-benzene is similar, but more energetic.

Amides.—Formamide acts on the spinal cord, a dose of 0.3 gram per kilo., causing in the frog convulsions, paralysis, and death from failure of respiration. Injected into the jugular vein of the dog, it acts on the vaso-motor and respiratory centers, and on the cardio-inhibitory centers in the medulla oblongata, causing the blood pressure to fluctuate below and above the normal, checking the respiration, and slowing the pulse. Successive doses, amounting to 1.5 grams per kilo., permanently lower the blood pressure, and cause death from respiratory paralysis. Small doses of *acetamide* injected into the dog raise the blood pressure, increase respiration rate, and diminish the pulse rate by the action of the cardio-inhibitory centers. Large doses (up to 5 grams per kilo.) may be injected with immunity, but these, after a time, cause extreme drowsiness and sleep. The effect of *propionamide* in the dog is small: doses of 0.25 gram per kilo. strengthen the beat of the heart, lower the blood pressure, and act on the cardio-inhibi-

tory centers, checking the pulse. *Benzamide* diminishes sensibility and reflex and voluntary activity in the frog. The fatal dose is 1.0 gram per kilo. Administered to the dog, it produces the additional effects of staggering, salivation, lowered temperature (1-2°), quickened respiration, and lessened pulse rate. Death results from failure of respiration. Injected into the jugular vein, it causes a rapid fall and rise in the blood pressure, but after repeated doses the pressure does not recover, and the heart is paralysed. The heart beat is lessened in force, the pulse becomes more frequent, and the respiration fails; at the same time, the pupils become dilated and sensibility is destroyed. The fatal dose is 0.5 gram per kilo. *Oxamide*, *thio-carbamide*, and *pyro-mucamide* have no appreciable effect on the dog.

Anilides. Formanilide administered to the dog by the mouth or subcutaneously in doses of 0.4 gram per kilo., acts on the respiratory centers, quickening the respiration; on the cardio-inhibitory centers and heart, successively raising and lowering the pulse rate; and on the vaso-motor centers, lowering the blood pressure; it lowers the temperature, increases reflex activity, and produces feebleness and coma, and death from respiratory failure. *Acetanilide* given to the dog causes vomiting, weakness, lowering of temperature, quickening of pulse, darkening of blood, due to formation of methemoglobin, and cessation of respiration. When injected into the circulation, it acts on the heart, reducing the blood pressure and successively quickening and slowing the pulse. The rate of respiration at first increases, but ultimately diminishes and fails, causing death. The fatal dose is 0.3 gram per kilo. *Benzanilide* injected into the jugular vein of the dog at first increases the blood pressure, but after the administration of several doses diminishes it. It also quickens the respiration and lowers the temperature. It is probable that the action of the drug is due to mechanical clogging of the capillaries of the nerve centers by the deposition of fine crystals, since enormous doses may be taken into the stomach without any appreciable effect.

PEPTOTOXIN.

E. Salkowski (*Virchow's Archiv*, 124, 409; *Jour. Chem. Soc.*, 60, 1267). As a result of experiments on the digestion of proteids by means of pepsin, no poisonous substance soluble in water and

amyl alcohol was formed, such as Brieger states he isolated from digested fibrin; in other words, a "peptotoxin" in Brieger's sense of alkaloidal substance does not exist.

If putrefaction is prevented, leucine and tyrosine are also never formed in gastric digestion.

If putrefaction be allowed to occur, poisonous basic products make their appearance. Some specimens of meat contain poisonous bases previous to the occurrence of digestion at all. The resinous substance present in commercial amyl alcohol is also toxic. These facts, no doubt, explain Brieger's error.

That albumoses and peptones are toxic, none will deny; the object of the present research is to show that their toxicity is one of their inherent properties and not due to any basic product or toxine separable from them.

OPHTHALMOLOGY.

CONDUCTED BY

ALVIN A. HUBBELL, M. D.

CAUSES, PROGNOSIS, AND TREATMENT OF INCIPIENT CATARACT.

Dr. S. D. Reisby, of Philadelphia, (*Ophthalmic Review*, August 1891,) has made an interesting contribution to this subject, in which he maintains that cataract, although a disease of advanced life, is not necessarily a senile change, but originates in certain local irritative, congestive, and subacute inflammatory processes of the retina and choroid induced by eye-strain, overtaxing the eyes, especially during some constitutional depression, exposure to glares of light or to intense heat, etc. These chronic pathological states materially affect and impair the nutrition of the crystalline lens, as well as other non-vascular tissues of the eye, and cataract begins to appear. The uncorrected errors of refraction are, doubtless, the most frequent cause of these states. In the stage of incipiency, cataract is amenable to treatment by such measures as are calculated to remove the pathological conditions upon which it depends. We are, therefore, justified in giving a more hopeful prognosis to many persons with commencing cataract. Although the treatment, however, may fail to arrest the progressive degeneration of the lens, the eye by virtue of the treatment adopted will be in a better condition to submit to the trials of surgical interference.

MODIFIED OPERATION FOR ADVANCEMENT OF A RECTUS TENDON.

Dr. D. Argyll Robertson, of Edinburgh, (*British Medical Journal*. August 29, 1891,) describes the following method of advancing an internal rectus muscle of the eye: The tendon of the internal rectus muscle is exposed and caught in a Prince's strabismus forceps: next, the tendon of the external rectus is divided subconjunctivally. The internal rectus is then divided close to its sclerotic insertion, and the muscle is held up and cleared for some distance of its attachments to conjunctiva and ocular capsule. The next step consists in the introduction of the ligature. A fine waxed black-silk thread is taken, to either extremity of which a fine curved needle is attached. One of these needles is threaded in and out through the base of the tendon, which is pulled forward by Prince's forceps. This, though it seems a weak hold, has, in practice, proved quite sufficient. One of the needles is now passed in and out, under and over the conjunctiva, close to the upper margin of the cornea, until a point well beyond the outer margin of the cornea is reached. In like manner the other needle is passed under and over the conjunctiva close to the lower margin of the cornea, till a corresponding point beyond the outer margin of the cornea is reached. A small bit of the extremity of the internal rectus tendon (varying in amount according to the effect desired) is then snipped off, the ends of the ligature tightened, until the cornea is well directed inwards, and tied. To facilitate the tightening of the ligature, the cornea may be rolled in by the use of forceps. The edges of the conjunctival incision are brought together by a couple of sutures, and the operation is ended. Sometimes the traction of the ligature causes the conjunctiva at some points to overlap the margin of the cornea, but this does not interfere in any way with the success of the operation. The ordinary antiseptic washings and dressings are employed. Both eyes are bandaged for twenty-four hours, so as to keep the eyes thoroughly at rest, and the eye operated on for one other day. On the fourth or fifth day the ligature is removed. This is easily done by dividing it in any part of its course, and pulling on the knot.

TREATMENT OF CHRONIC GRANULAR CONJUNCTIVITIS.

During the past few years several ophthalmic surgeons have prominently brought forward and recommended the old method of

expression of conjunctival granulations. Dr. Knapp, of New York, has recently been using a form of roller-forceps by which the conjunctival tissues are grasped, and as they are pulled away, press out the infiltrated matter without much laceration, acting as a mangle or wringer in squeezing water out of clothes. He has found that follicular trachoma can be permanently cured at one sitting, without subsequent contraction or scars. Mixed forms are greatly benefited, but may require other treatment, too.—*Medical Record*, October 3, 1891.

Dr. Weeks, of New York, has recently reported in favor of treating granulations by *grattage*. This method has been used considerably in Paris. He believes that it is better suited to certain stages of trachoma than expression, especially that stage in which the granules have coalesced, the conjunctiva becoming cicatricial, and where the tarsus is somewhat swollen and thickened, and vascular pannus and superficial keratitis have developed. He describes the operation as follows: Anesthetize the patient. It may be necessary to do canthoplasty, or canthotomy. By use of forceps and knife, the conjunctival surface is scarified, the scarifications running parallel to the lids, close together, and united by a few transverse incisions, the depth of the incisions depending on the depth of the trachomatous tissue. All parts of the conjunctiva affected with trachoma being thus scarified, the surface is then thoroughly scrubbed with a tooth brush carrying one to 500 bichloride solution. The two lids are afterwards freed from clot, and a bandage and antiseptic dressing applied. Very little reaction follows. The process may need to be repeated.—*Medical Record*, October 10, 1891.

MEDICAL JURISPRUDENCE.

CONDUCTED BY HENRY A. RILEY, A. B., LL. B., New York

CORONERS' JURIES AND THE PARK PLACE DISASTER.

THE terrible accident in New York City not long since, by which some sixty-four persons lost their lives through the collapse of a building, where heavy printing machinery was stored, has served to call to mind not only the defects of the building laws, which permit the overloading of buildings where it may be scores of persons are employed, but also the peculiar workings of the system of coroners' inquests. It was supposed by the public that

such an appalling disaster would bring home to some one the charge of criminal negligence in not looking more carefully after the safety of human lives.

The coroner's jury failed, however, to find anyone responsible, and laid the whole fault upon the defects of the law, which did not provide for the services of a sufficient number of inspectors to properly examine buildings where heavy machinery was stored. The grand jury has also just taken the same view of the matter, and consequently there will be no prosecutions whatever. The latter body makes the following recommendation for legislation, which is certainly timely: "The placing within any building of a greater weight than the building is capable of safely supporting, should be made a felony, and the fact of such overloading being established, the owner, as well as the occupant of the building, or the part thereof overloaded, should be *prima facie* guilty."

COURTS DIFFER IN REGARD TO INHALING GAS.

The United States Circuit Court for Illinois differs with the Court of Appeals of this State on the question of the liability of accident insurance companies for death by inhaling gas.

In a recent case in Chicago, a person was found dead at a hotel with the gas turned on in the room. There was no visible sign of violence or external injury on the body, and nothing to show whether it was a case of suicide or an accident. The limbs and features were not distorted, and the victim was lying naturally on his side in bed. He held a policy of accident insurance in the Travelers' Insurance Co., which expressly relieved the company from all liability when death occurred by inhaling gas. The court held that the company need not pay the policy, and quoted the adverse opinion in a case in the New York Court of Appeals, where it was said: "In expressing the intention not to be liable for death from inhaling gas, can only be understood to mean a voluntary and intelligent act by the insured, and not an involuntary and unconscious act. Read in that sense and in the light of the context, these words may be interpreted as having reference to medical or surgical treatment in which *ex vi termini* would be included the dentists' work or a suicidal purpose."

The Illinois court comments on this decision and says: "The reasoning by which that court reached its conclusion is not satis-

factory to my mind. The language of the policy is so clear as not to require any construction. The words are unequivocal that the defendant does not insure against death caused by inhaling gas.

There is nothing in the terms of the policy intimating or suggesting that the inhalation of gas must be voluntary or involuntary in order to exempt defendant from liability. That the defendant had the right to so limit its liability, there can be no doubt."

MALPRACTICE AND MORPHINE.

A South Dakota court has now before it a suit for money damages against a physician who, it is alleged, has by continuous hypodermic injections of morphine, rendered a patient a mental and physical wreck. The action is brought by the wife, who states that she has been deprived of her support through the improper treatment of the physician.

This is a novel case, and yet foreshadows what may be a long line of malpractice suits, for there is little doubt that the morphine habit is growing, and that physicians are sometimes responsible for the sad results.

A NOVEL PUNISHMENT FOR TRESPASSING.

An English surgeon, not long since, found two boys trespassing in his garden, and, by way of punishment, painted their faces with lunar caustic, producing the representation of a moustache and imperial. When the boys got home, their faces were dressed with oil, but they complained very much of the pain, and the next day one of them was sent home from his place of work because the employer objected to his facial adornment. The parents afterwards brought an action against the physician, and medical evidence was given as to the nature of the injuries.

The court fined the surgeon five shillings and costs.

A NEBRASKA MALPRACTICE CASE.

In a Nebraska court recently a physician was sued for $10,000 for alleged malpractice. The patient and her husband claimed that the physician had performed an abortion, while he asserted that he had removed a tumor.

The jury granted a verdict for $97.50, which was the exact amount recovered by the physician in a previous action for medical services.

New Instruments.

A NEW AND IMPROVED FORM OF CLUB FOOT SHOE.

By ROSWELL PARK, M. D., Buffalo, N. Y.

The ideal club-foot shoe, which shall be both *light*, *durable*, and *effective* in the highest degree, has, perhaps, not yet been constructed. That form, however, which is represented in the accompanying

illustration, more nearly attains to my ideal than any that I have yet used. It is practically a combination of the good features of several others, and as made for me by Messrs. Stoddart Bros.' excellent workmen, it accomplishes its purpose admirably.

Like all surgeons, I have found it necessary in the majority of cases of club-feet to correct not only the displacement of the tarsal bones and their distortion, but to overcome an inward (or outward) rotation of the tibias, sometimes even of the femurs. By a swivel-joint a little above the ankle, and, if necessary, by another above the knee, operated by a spiral spring with ratchet-joint, any desired amount of internal or external rotary tension or twist can be given. It is intended that this apparatus shall be worn night and day, at least for a time, in order that an impetus to growth in the corrected position may thus be given. Of course, for this purpose, the apparatus must be connected with a pelvic band. *All other forms* not thus giving a firm point of support *fail to accomplish their purpose.*

By means of one or two lock-joints about the ankle or near the sole, any desired position of the foot may be secured and maintained.

For two years I have used this apparatus, and a considerable number of cases has served to test its merits and efficiency. Thus far it has proved to be the least disappointing and the most reliable of any that I have ever used. There are no wire chains or rubber cords about it, nor any hooks or eyes nor other parts to break off easily, and if properly constructed it will be found to far outlast the common shoes made and sold for the purpose.

BUFFALO MEDICAL AND SURGICAL JOURNAL

A MONTHLY REVIEW OF MEDICINE AND SURGERY.

EDITORS:

THOMAS LOTHROP, M. D. - - WM. WARREN POTTER, M. D.

All communications, whether of a literary or business character, should be addressed to the managing editor: 284 FRANKLIN STREET, BUFFALO, N. Y.

VOL. XXXI. JANUARY, 1892. No. 6.

THE STREET CARS AND THE PUBLIC HEALTH.

WE RETURN to this subject, after a somewhat prolonged silence, for the purpose of reminding our readers that the evils heretofore complained of in regard to the street-car service in this city have not been corrected.

Our municipal government is about to inaugurate a new era in the administration of sanitary affairs, and we have very much misjudged the mettle of the new executive, who takes office as Health Commissioner with the beginning of the new year, if we do not find him at once making active endeavors to improve the sanitary condition of the street cars.

The proper management of street cars implies an enforcement of the following conditions: first, absolute cleanliness of each and every car; second, the proper heating of all street cars in Winter; third, no hay or straw to be allowed in any car; fourth, frequent inspection by competent officers, whose duty shall be to see that these regulations are strictly carried out.

We need not enter into an argument as to the propriety of heating the cars from a sanitary standpoint. No person is foolish enough nowadays to claim that heated air is unhealthy air, or that the heating of air necessarily befouls it. Every person with a grain of common sense about such matters knows that a street car can be much better ventilated if it is also heated. Twenty or thirty people crowded into a street car on a frosty morning, without ventilation, and trampling dusty hay or straw, presents a picture of about the worst condition imaginable from a sanitary standpoint. On the other hand, a well-warmed, cleanly car that is properly ventilated with clean rubber matting on the floor, presents a picture of about the nearest approach to perfection that can be obtained from a

sanitary standpoint. In these days when so many people are availing themselves of the street cars as a method of transit, it behooves a municipality of the size, intelligence, and importance of Buffalo to exercise the most scrupulous care, and watch with the most jealous eye all avenues that may tend to the propagation or transmission of disease. We have naught but the highest respect for the distinguished gentleman who stands at the head of our street railways in the capacity of president of the corporation, but we certainly have no respect for his unsanitary management of that all-powerful as well as very necessary corporation.

The only wonder is that an intelligent and long-suffering community has endured for so many years the insults that have been daily offered to the special senses of sight, smell, and touch by the uncleanly, unventilated, unheated, and hay-bestrewn street cars that have been tendered as means of transit in Winter to its good-natured inhabitants. But we warn the street car management that the time for deliverance is near at hand; good nature has been over-taxed, and in our new Health Commissioner we have a man who will not hesitate to take the responsibility of correcting evils that menace the health of the city wherever they may be found.

EDITORIAL RETIREMENT OF DR. MUNDÉ.

Dr. Paul F. Mundé announced in the December number of the *American Journal of Obstetrics* that at the close of the year he would retire from the editorial management of that journal.

For eighteen years Dr. Mundé has successfully conducted the first journal in this country to be devoted to the consideration of a special department of medicine. During this period the life of Dr. Mundé has been so completely interwoven with that of the *American Journal of Obstetrics*, that it is difficult to think of the one without indistinctively being minded of the other. To say that this long editorial career has been a complete success is only to repeat what everybody in the profession already knows.

At the annual dinner of the American Association of Obstetricians and Gynecologists given at the Academy of Medicine, in the City of New York, on the evening of September 18, 1891, Dr. Mundé was invited to respond to the sentiment *The American Journal of Obstetrics*. In the course of his timely and eloquent little speech, he referred to the fact that this change was about to occur, and he further remarked, that in his whole editorial career, this was the

first occasion when the journal, with which he had been so indissolubly connected for eighteen years, had been noticed in a public manner, or spoken of in a conspicuous way at a banquet. He seemed as much touched by the references to his journal as those present were by his speech, and especially by the fact that it foreshadowed his retirement from the editoral management thereof.

He leaves the journal so thoroughly established in the hearts of the profession, that it need have no fear of being supplanted by any other periodical. There may be, and no doubt is, a field for other good journals, but the *American Journal of Obstetrics* will live as long as the science which it expounds is recognized as a distinct specialty.

Dr. Mundé commits the journal to an able successor, Dr. Brooks H. Wells, who has been his assistant in its conduct for several years, and who has won the respect and affection of every one of the contributors and patrons of the journal with whom he has come in contact.

We regret that Dr. Mundé must retire, but since this must be, we congratulate the publishers upon securing the services of so able and polished a successor. In bidding adieu to Dr. Mundé, we hail Dr. Wells.

SANITARY CONDITION OF PUBLIC SCHOOLS.

The Medical Society of the County of New York, at its regular meeting, held November 23d, adopted the following resolution, offered by Dr. A. Jacobi: *Resolved*—That the Board of Health be requested to use both its actual authority and its moral influence to secure for the school children a sufficient amount of air, light, and accommodation, and to protect them from dangers to their health unavoidable in the present condition of the public schools.

If some action of this nature should be taken by the medical societies of this city, it might possibly result in stimulating the authorities to proper action. It is a notorious fact that in Buffalo there is an over-crowding in our public schools, as well as an improper ventilation in a number of school buildings, and not a few are inadequately served with water. The three conditions that should be insisted upon by the health authorities with reference to each and every school building within its jurisdiction of this city, should be,—first, an ample supply of fresh air in and about the public schools; second, proper heating and ventilation of every school

room; third, adequate water supply to meet all the necessities and exigencies of the services.

This will be another problem for the new Health Commissioner to solve, and we presume he will address himself promptly to the work upon his induction into office. No more important service can be rendered the city than to put its public schools upon a proper sanitary basis, for education obtained at the expense of health is worse than useless.

OHIO MOVES FOR STATE LICENSE.

On Thursday, December 3, 1891, a meeting of the representatives of the several medical colleges in the State of Ohio was convened at the Neil House, at Columbus, upon the call of Dr. Chas. A. L. Reed, of Cincinnati.

The object of this meeting was to consider the propriety of asking the State Legislature, at its approaching session, to pass a law providing for a State Medical Examining and Licensing Board, and further to seek the coöperation of the medical societies and physicians throughout the State in bringing about such desirable legislation.

One delegate from each medical college was invited to attend the conference, and it is understood that every college was represented at the meeting. In view of the fact that there had been some recent exposures in regard to the selling of diplomas in that State, this seems to be an opportune moment to unite the profession and the colleges, as well as all progressive and law-abiding citizens, in an effort to render such nefarious schemes impossible in the future.

We wish our neighbors and *confrères* in Ohio a full measure of success in their worthy undertaking, but we warn them that they will meet opposition from every possible source—regulars, irregulars, and quacks—so they must be on the alert in order to overwhelm the unscrupulous combinations of designing men.[1]

Chloralamid in Epilepsy.—At the October meeting of the New York Academy of Medicine, Dr. Chas. L. Dana, Professor of Diseases of the Mind and Nervous System, New York Post-Graduate Medical School, in speaking of the symptomatic treatment of epilepsy, refers to chloralamid as follows: "The most valuable adjuvant was hydrate of chloral, but I have found a new drug in chloralamid, which does all the good ascribed to the former drug, without affecting the heart or circlation."

1. Since the foregoing was written, we have received the minutes of the meeting referred to, and publish them in another column.

Obituary.

Dr. Lucien Damainville died in New York, on Tuesday, December 15, 1891, aged fifty-two years. Dr. Damainville was a former resident of Buffalo, and it will be remembered by old Buffalonians, that his father was one of the prominent Frenchmen early identified with the history of the city. Lucien himself was a student of the late Dr. Frank Hastings Hamilton when he was professor of surgery in the University of Buffalo, and was a classmate and companion of the writer during the latter part of the fifties.

When Dr. Hamilton went to New York, Dr. Damainville also carried his fortunes hitherward, where he was more or less associated with his chief for many years. They entered the military service substantially together, Dr. Hamilton as surgeon of the thirty-first regiment, New York volunteers, and Dr. Damainville, as assistant-surgeon in the same regiment. The regiment was commanded by Colonel — now judge — Calvin E. Pratt, of Brooklyn, who presided recently at the New England dinner given at the Brooklyn Academy of Music. Judge Pratt and Dr. Hamilton, as well as Dr. Damainville, were always warm personal friends, hence this allusion to their relationship.

After Dr. Hamilton's promotion to be surgeon of United States volunteers, Dr. Damainville succeeded him as surgeon of the thirty-first, in which office he continued until the expiration of the term of enlistment of the regiment. After the war, Dr. Damainville returned to New York, and has continued in the practice of his profession in that city until his death, serving for a number of years as Surgeon of Police. He visited Buffalo in 1883, in company with Dr. Hamilton, which was the latter's last visit to his old home, and it is the impression of the writer that Dr. Damainville himself has not visited Buffalo since that time.

Dr. Damainville was a man of positive convictions, able in his profession, and studious in his habits. We mourn his loss as one of his friends as well as his colleague in the profession that he loved so well.

Dr. Henry Fraser Campbell, of Augusta, Ga., died at his home on Tuesday, December 15, 1891, in the sixty-eighth year of his age. He graduated in medicine in 1842, and settled in Augusta the same

year, where, except during the period of the war and two Winters spent in New Orleans, he has remained and practised his profession.

His earlier achievements were made as a general surgeon, but for many years he has been distinctly known as a gynecologist. Dr. Campbell has been an extensive and voluminous writer, and has contributed some of the most valuable papers to the literature of surgery and gynecology of any man in modern times. His fame as a teacher and writer extended beyond his own country, and in Europe his name was almost as well known as among his colleagues at home. He was a member of all the prominent societies in his State. He was president of the American Medical Association in 1885, and has been for some years an active member of the American Gynecological Association, and still later of the Southern Surgical and Gynecological Association.

He was a man of great amiability of character, a genial companion, whose face was always a gleam of sunshine, and who lent himself heartily to the promotion of health, happiness and longevity wherever his ministrations were sought or rendered. He leaves a family who were devoted to him both as husband and father, and for whom we express our tenderest sympathy.

Personal.

Dr. Nelson Saunders, of Randolph, N. Y., who has been ill for some weeks past, is reported convalescent, and his many friends will be glad to know that his recovery is confidently expected.

Dr. George Ben. Johnston, of Richmond, Va., was elected vice-president of the Southern Surgical and Gynecological Association, at its recent meeting, held in the capital of the Old Dominion. Dr. Johnston, who is a nephew of that distinguished soldier, Gen. Joseph E. Johnston, is one of the most genial and accomplished men of the South, and it was a fitting recognition of his ability to place him high on the list of officers of this excellent Association.

Dr. W. A. Putnam has been appointed surgeon of the Lake Shore R. R., at Westfield, *vice* Dr. Thomas D. Strong, resigned.

Medical College Notes.

COLUMBUS, O., December 3, 1891.

PURSUANT to call issued by the Cincinnati College of Medicine and Surgery for a delegated convention of the medical colleges of the State of Ohio, to be held at Columbus on the date above mentioned, representatives of the following faculties were present, viz.:—Starling Medical College, Toledo Medical College, Pulte Medical College, Columbus Medical College, Medical Department of the National Normal University, College of Physicians and Surgeons of Columbus, Woman's Medical College of Cincinnati, and the Cincinnati College of Medicine and Surgery.

On motion, Dr. STARLING LOVING was elected Chairman, and Dr. CHARLES A. L. REED, Secretary.

On motion of Dr. C. E. WALTON, representatives of the Physio-Medical Society of Ohio were admitted to a vote in the convention.

Dr. CHARLES A. L. REED presented the following:

Resolved, By the medical colleges of Ohio, in convention assembled, that the Legislature be and is hereby requested to enact a law which shall embody the following features, viz.:

1. The creation of a board or boards of medical examiners, in the composition of which equitable and just representation shall be accorded to the various recognized denominations of medical practice.

2. The examination of all candidates for the practice of medicine holding diplomas hereafter issued by medical colleges which shall be deemed in good standing by the board.

3. Exemptions from examination to extend only to those who at the time of the enactment of this law shall be recognized as legal practitioners within the meaning of existing statutes; but all legal practitioners shall be required to register.

4. A penal clause which shall secure the enforcement of the foregoing provisions.

Dr. C. E. WALTON, on behalf of the Legislative Committee of Cincinnati, presented the registration law approved and promulgated by that committee.

On motion by Dr. SHOCKEY, the resolutions presented by Dr. Reed were approved.

On motion by Dr. KINSMAN, the Secretary was directed to forward transcripts of these proceedings to each local medical society in Ohio, and to the medical press.

On motion by Dr. Scoville, a committee was appointed to confer with the Legislative Committee of Cincinnati for the purpose of securing such changes in the bill proposed by that committee as to make it conform to the resolutions adopted by this convention.

The chair appointed as such committee: Drs. S. S. Scoville, T. C. Hoover, G. W. Mayhugh, and Chas. A. L. Reed. Adjourned.

University of Buffalo, Department of Pharmacy. — The laboratories of this school are being refurnished and new apparatus supplied. There are bright prospects for a large first year class, a considerable proportion of the new students coming from out of the city. Prof. Long will devote more time to toxicology than previously. Prof. Wende will make no radical change in the microscopic course, but the junior work will be somewhat increased. Dr. Benedict will devote more time to plant classification than last year; otherwise the botany course will remain practically unaltered.

A material increase in the hours of study for the juniors will be made. Arrangements have just been completed for the purchase of a set of 150 different pharmacopeial drugs. These will be added to the already large collection of botanical and pharmacological specimens. Although the college does not contract to furnish positions to students, it has been found that students with previous experience in drug stores have had no difficulty in obtaining situations. The members of the faculty render all possible assistance in this regard.—*Bulletin of Pharmacy, October, 1891.*

Mrs. C. P. Huntington has given the directors of the Post-Graduate Medical School $3,000, a sum sufficient to defray the expenses of the lying-in department for one year. Prof. von Ramdohr will have charge of this department, at 543 East 13th street, where instruction in obstetrics will be given to graduates in medicine only.

Medical Societies.

Membership in the American Pharmaceutical Association is obtained only by election at the annual meeting. "Every pharmacist and druggist of good moral and professional standing, whether in business on his own account, retired from business, or employed

by another, and those teachers of pharmacy, chemistry and botany who may be especially interested in pharmacy and materia medica" are eligible for membership. For blank application and further information, address Dr. H. M. Whelpley, 2729 Washington avenue, St. Louis, Mo., Chairman of the Committee on Membership.

The second annual session of the Association of Military Surgeons of the National Guard of the United States will be held at St. Louis, April 19, 20, and 21, 1892. An interesting programme of addresses by prominent surgeons of the National Guard and the United States Army has been arranged, and a goodly number of scientific papers on Military and Accidental Surgery will be read and discussed, and all matters pertaining to the health, usefulness and welfare of the civilian soldiers will receive attention. Dr. Nicholas Senn, of Chicago, is President; Dr. Frederick L. Matthews, Springfield, Ill., is Secretary, and Dr. Eustathius Chancellor, of St. Louis, is Chairman of the Committee of Arrangements.

Book Reviews.

Practical Pathology and Morbid Histology. By Heneage Gibbes, M. D., Professor of Pathology in the University of Michigan; formerly Lecturer on Normal and Morbid Histology in the Medical School of the Westminster Hospital, London; formerly Curator of the Anatomical Museum, King's College, London. Illustrated with sixty photographic reproductions. Octavo, pp. xii.—320. Philadelphia: Lea Brothers & Company. 1891.

A new work on Pathology by an American author is always hailed with interest and pleasure. Such was the feeling when Professor Gibbes's work first appeared. The original researches, which have been instituted by him within the past few years, have given his name a prominence in this field of medicine. We regret that this work is intended for laboratory students, instead of being an exhaustive treatise on the subject.

The first seven chapters are devoted to the preparation of the material, and is a careful and painstaking description of the different processes of mounting, staining, etc. We, however, question the advisability of incorporating these chapters in a work on pathology, because, with but little exception, they are the same as are in vogue in normal histology, and no student should study

pathology before he knows microscopy and histology quite thoroughly.

Chapters VIII. to XIII. are devoted to the study of Bacteriology, and here again we feel as if the subject of pathology must suffer by just so much. Today bacteriology is regarded as so separate a branch, that it seems out of place in a work on pathology.

In chapter XIV. the real subject is taken up. The degenerations and inflammations deserve, perhaps, more attention than they have received; still, as discussed, they must convey to the reader a good knowledge of the changes which they provoke in the system. The tumors are next taken up, the fibromata and sarcomata being exceptionally well presented. Most authors pass by hurriedly the different forms of fibroma, such as fibrous epulis, nasal and rectal polypi, etc., but not so in this work.

The chapters on Diseases of the Heart, and Nervous System, are treated much too sparingly, even for students; whereas, the chapters on Diseases of the Lungs and Arteries deserve special commendation. The chapters on the Liver, Kidney, Spleen, Tongue, etc., are briefly but ably discussed.

Part IV., chapters XLI. to XLIV., are devoted to photography with the microscope, and here again the methods and formula are fully and thoroughly described. The illustrations, sixty in number, are all micro-photographs. Some of them are great aids, but some convey little meaning, especially the illustration of a spindle-celled sarcoma, page 165, and the melanotic sarcoma, page 169. Until we can photograph colors, thereby distinguishing between a cell body and cell nucleus, micro-photography will be of little service in microscopical pathology.

The publishers, as usual, have contributed their full share towards making it a pleasing and desirable work. W. C. K.

THERAPEUTICS: ITS PRINCIPLES AND PRACTICE. By H. C. WOOD, M. D., LL.D., Professor of Materia Medica and Therapeutics, and Clinical Professor of Diseases of the Nervous System, in the University of Pennsylvania. A work of Medical Agencies, Drugs and Poisons, with especial reference to the relations between Physiology and Clinical Medicine. The eighth edition of Treatise on Therapeutics rearranged, rewritten, and enlarged. Octavo, pp. 937. Philadelphia: J. B. Lippincott Company. 1891.

It is so recently (October, 1888,) that we had occasion to speak in these columns in reference to the value of Dr. Wood's Treatise on Therapeutics, when we reviewed the seventh edition, it seems almost a marvel to find ourselves now called upon to mention the

eighth edition of this matchless work. The fact that another edition is called for so soon, will serve, in a certain degree, to mark the rapidity of movement that is making in the science of therapeutics as applied to the treatment of disease. Dr. Wood has made himself so distinctly an authority on this subject, that no one presumes to question the fact that Wood's Therapeutics is rapidly becoming an American classic. In the present edition the author has brought forward everything pertaining to his subject to the latest date, and, taken altogether, it is one of the most complete single volume treatises on therapeutics extant.

This edition has been thoroughly revised, and some of the work is practically new. For instance, the whole subject of Anesthetics, the articles upon Cocaine, Strophanthus, Caffeine, Antipyrin, Antifebrin, Phenacetin, Hydrastin, Paraldehyd, Lead-poisoning, etc., have been rewritten; while the articles on Sulphonal, Chloralamid, Aristol, and some others, are entirely new.

We recommend every student of medicine to obtain Wood's Therapeutics, and every practitioner who would freshen up his library, should do likewise.

The publishers are entitled to high commendation for the part they have played in putting forth this new edition so promptly and handsomely.

A Short Manual of Analytical Chemistry, Qualitative and Quantitative, Inorganic and Organic. Arranged on the principle of the course of instruction given at the South London School of Pharmacy. By John Muter, M. A., Ph. D., F. R. S. E., F. I. C., F. C. S., Analyst to the Metropolitan Asylum Board; Public Analyst for Lambeth, Wansworth, Southwark, Newington, Rothershithe, and the Linsey Division of Lincolnshire; Past President of the Society of Public Analysis; author of Pharmaceutical and Medical Chemistry (Theoretical and Descriptive), A Key to Organic Materia Medica, late editor of *The Analyst*, etc., etc. First American from the fourth English edition, edited by Claude C. Hamilton, M. D., Ph. G., Professor of Analytical Chemistry in the University Medical College and the Kansas City College of Pharmacy; Professor of Chemistry in the Western Dental College of Kansas, Missouri. Octavo, pp. 205. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut street. 1891.

This volume, which comes from the pen of a public and private analyst of wide reputation, is an excellent one, and contains within its two covers a great deal of valuable information. Although primarily intended for students, it is of value to the busy analyst as well, for the methods are given in clear and concise manner, thus rendering a saving of time, which is further increased by an excellently arranged index.

We wish to call the editor's attention to what we believe is an oversight. On page 166, under the heading Fat, the author says: "The following method of estimating fat is generally followed by most of the official milk analysts of America: Replace the dish containing the total solids upon the water bath, and fill from a wash bottle with petroleum naphtha of the quality of benzine (U. S. P., 1880). Allow the benzine to boil down to about one-half, and decant against a rod into a basin, replace upon the water bath, and again refill with naphtha, and decant. Repeat this four times, then wash the outside of the capsule with benzine, dry the dish, and weigh as in total solids. The loss of weight of the total solids is the fat in 5 c.c. of milk taken." We do not believe that the best analysts of this country use this method today. At all events it is not a method which would stand much show in a court of law, and official analysts do, or always should, bear in mind that methods may be questioned by attorneys.

From the reference (U. S. P., 1880,) we judge that this was taken from the U. S. P., which is a decidedly unreliable book from which to get the analytical methods of today.

The typography and general make-up of this volume is in the usual excellent style and good taste so characteristic of these publishers.

J. A. M.

A Clinical Text-Book of Medical Diagnosis for Physicians, based on the Most Recent Methods of Examination. By Oswald Vierordt, M. D., Professor of Medicine at the University of Heidelberg; formerly Privat-Docent of the University of Leipzig; later Professor of Medicine and Director of the Medical Polyclinic of Jena. Authorized translation from the second improved and enlarged German edition, with additions. By Francis H. Stuart, A. M., M. D., New York. With 178 illustrations, many of which are in colors. Octavo, pp. xvi. — 700. Philadelphia: W. B. Saunders. 1891. Price, cloth, $4.00 net; sheep, $5.00 net.

The subject of medical diagnosis is one always fraught with interest, and its importance is concededly of the first. The work before us is written by a man of experience and judgment, and it cannot fail to command the attention of the American medical profession. It is difficult for any author on this subject to gain a footing in the schools as against DaCosta, who has held sway so long, but we are of the opinion that Vierordt has constituted himself a successful rival, whose treatise will compete for the honor of being assigned as a text-book in the American college courses.

This work possesses the merit of being entirely abreast of

modern science in every respect, as applied to the diagnosis of disease. It is illustrated with clear cuts in wood and in colors, which elucidate the author's meaning in an admirable manner. No student can be considered equipped for the final examination until he has mastered questions of diagnosis, and no physician is competent to treat disease until he is thoroughly skilled in the principles and technique of differential and absolute diagnosis of disease. Vierordt classifies his treatise in a systematic and business-like way. He divides his subjects into three general parts. In Part I. he gives an introduction and a chapter on the Examination of Patients; in Part II., general examination is considered; in Part III., the special examination of the several tracts, apparatuses and systems of the viscera are discoursed upon. His sentences are clear, epigrammatical, and finished. His style is that of a scholar who knows what he is writing about, says what he has to say, and stops without a superfluous word or sentence. The consequence is that into this work there is crowded an immense amount of material such as cannot be found in any treatise in the corresponding space. The index is a copious one, indeed, one of the best we have ever seen, which comprises about ninety pages of the volume. We advise every student of medicine to possess this work with little delay, and every practitioner would do wisely if he should add it to his library. The publisher has presented it in a most attractive form.

THE COMPARATIVE ANATOMY OF THE DOMESTICATED ANIMALS. By A. CHAUVEAU, M. D., LL. D., Member of the Institute (Academy of Sciences); Inspector-General of Veterinary Schools in France; Professor of the Museum of Natural History, Paris. Revised and enlarged, with the coöperation of S. Arloing, Director of the Lyons Veterinary School, Professor of Experimental and Comparative Medicine at the Lyons Faculty of Medicine. Second English edition, translated and edited by George Fleming, C. B., LL. D., F. R. C. V. S., Late Principal Veterinary Surgeon of the British Army; Foreign Corresponding Member of Société Royal de Medicine, and the Société Royal de Medicine Publique, of Belgium; Foreign Associate of the Société Centrale de Medicine Veterinaire of France; Honorary Life Member of the Royal Agricultural Society of England; Foreign Member of the Société Nationale d' Agriculture of France, etc.; Examiner in Anatomy for the Royal College of Veterinary Surgeons. With 585 illustrations. New York: D. Appleton & Co. 1891.

The scope of this valuable work is limited to what the author calls veterinary anatomy; but the veterinary surgeon is not the only one to receive the benefit of its teachings. Even the medical man, who has not given time to the study of comparative anatomy in its more comprehensive form, may find much in its pages to

interest him. Founded on human anatomy, from which its nomenclature is largely borrowed, all that is necessary to enable one not familiar with this science is clearly given both in text and illustrations, to enable him to follow the author, so as to get a very clear idea of the analogies and differentials between the lower animals, of whose structure and histology he treats.

At the outset we have an enumeration and classification of domesticated animals, general ideas of their organization and description of the various cells and tissues which go to make up the framework and physiology of a domestic animal, with all the apparatuses necessary to its life and well-being. The bony framework of the various classes is well illustrated and described, and the differentiations between them, as well as their general similarity of plan to the human body, are clearly seen at a glance. So of the muscular arrangement and adaptation throughout the whole range, from the camel to the domestic fowl.

Such a work as this cannot fail to interest all who are interested in domestic animals; and who is not? Of course, to the veterinary doctor it is a *sine qua non*, and no painter or sculptor of animal life can attain his highest ideal without familiarity with the science as recorded in its pages.

Too much cannot be said in praise of the beauty and adaptation of its 585 illustrations that run through its 1,050 pages. A very copious index gives the book additional value.

THE MICROSCOPE AND HISTOLOGY. PART I. The Microscope and Microscopical Methods. By SIMON HENRY GAGE, Associate Professor of Physiology, Cornell University, Ithaca, New York, U. S. A. Pp. VIII. + VI. + 96; five full page plates and eight figures in the text. Ithaca, N. Y.: Andrus & Church. 1891. Price, bound in heavy manilla, $1.00; half leather, $1.25.

Part I. of Professor Gage's prospective work on The Microscope and Histology, is now put upon the market in a new and convenient form. Originally intended for his students at Cornell University, it has outgrown those limits, and we bespeak for it a large and appreciative field. We know of no work on microscopy that so thoroughly and effectively discusses the principles and practice of this important science as Prof. Gage's book. The attention and scrutiny paid to details in the elements of a science, so characteristic of the Cornell school—thus laying a broad and solid foundation for the superstructure—cannot help but make students scientists before they leave the college halls. Prof. Gage

has collected material, especially the tables on Tube-Lengths, Cover-Glass Thickness, etc., of great value to the microscopists, which can be found in no other work on this subject. To the student or physician who wishes to study the microscope and methods, we can heartily recommend this work, and feel assured that the knowledge thus gained will be of inestimable value in pursuing the higher sciences, as histology, pathology, and bacteriology. We await with pleasure the appearance of Part II. on Histology.

Much credit is due Mrs. Professor Gage for the richly executed plates and drawings, which add materially to the value of the work.

Messrs. Andrus & Church have performed their work very satisfactorily, and deserve to be better known as publishers of scientific works. W. C. K.

Essentials of Bacteriology: Being a Concise and Systematic Introduction to the Study of Microörganisms for the use of Students and Practitioners. By M. V. Ball, M. D., late Resident Physician German Hospital, Philadelphia; Assistant in Microscopy, Niagara University, Buffalo, N. Y., etc. With seventy-seven illustrations, some in colors. Saunders' Question Compends, No. 20. Philadelphia: W. B. Saunders, 913 Walnut street. 1891.

As one of our exchanges has remarked, the "compends are the fruit of the two years' courses," but if we must have compends, we prefer to have them as complete and thorough as the word compend will allow. The book by Dr. Ball is an excellent little work, as far as it goes, and is on a level, if not superior, to those which have appeared in this series. The arrangement is admirable, and the many cuts, some in colors, add materially to its instructiveness. As an aid or guide for laboratory students already versed in bacteriology, it has its greatest value. W. C. K.

Practical Notes on Urinary Analysis. By William B. Canfield, A. M., M. D., Chief of Chest Clinic and Lecturer on Clinical Medicine, University of Maryland; Visiting Physician to the Union Protestant Infirmary, Bay View Hospital, Baltimore, etc. Physicians' Leisure Library, Detroit, Mich.: George S. Davis. 1891. Price, cloth, 50 cents; paper, 25 cents.

In this compact little book Dr. Canfield has grouped a vast amount of useful information in convenient form. It is on a subject of sufficient importance for every professional man to possess the book, and its cheapness brings it within the range of everybody's purse. We observe that Dr. Canfield insists upon spelling

albumin in the old way, with an "e," and yet he uses an "i" when he converts it into albuminuria. The last chapter in the book on the Order of Analysis is a very compact and useful presentation of a system that should prevail in every urinary analysis, and it is especially commended to examiners of life insurance as a guide.

A MANUAL OF PRACTICAL OBSTETRICS. By EDWARD P. DAVIS, A. M., M. D., Clinical Lecturer on Obstetrics in the Jefferson Medical College, Professor of Obstetrics and Diseases of Children in the Philadelphia Polyclinic, etc.; with 140 illustrations, two of which are colored. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut street. 1891.

The author states in the preface that the preparation of this book has been suggested by the needs experienced in teaching students of medicine, and he has incorporated such scientific facts as would meet the demands of the practitioner who requires the science so rendered that they are presented at a glance. The works of Parvin, Lusk, Schröder, Muckel, Carl Braun, Galabin and Dühussen have been used in the preparation of the book, thus aiming to furnish the latest and best thought of authorities resorted to by the profession. The author has succeeded well in this task, and presents a valuable little manual, which will subserve an excellent purpose for the student and practitioner, who have not the time to examine the larger works. In carefully perusing its pages, we are surprised that so much of the science and art of obstetrics can be presented in so small a compass. The book is one of the most practical of its kind to which our attention has been called.

ARTIFICIAL ANESTHESIA AND ANESTHETICS. By DEFOREST WILLARD, A. M., M. D., Ph. D., Clinical Professor of Orthopedic Surgery in the University of Philadelphia; Surgeon to the Presbyterian Hospital etc., and LEWIS H. ADLER, JR., M. D., Instructor in Rectal Diseases, Philadelphia Polyclinic and College for Graduates in Medicine. The Physicians' Leisure Library. Single copies, cloth, 50 cents; paper, 25 cents. Detroit, Mich.: Geo. S. Davis. 1891.

Every physician, no matter what his special line of practice, should thoroughly familiarize himself with the administration of anesthetics. With the constantly increasing necessity for their use both in medicine and surgery, it is important that all possible safeguards should be thrown around the administration of any drug which possesses local or general anesthetic effects. If every physi-

cian in the land would read this little work of Drs. Willard and Adler, they would certainly be better equipped for dealing with emergencies that may arise in the use of these important aids to the successful practice of medicine and surgery. Particularly do we commend the chapter on the Medico-legal Relations of Artificial Anesthesia, which is the last one in the book.

Essentials of Physiology, Arranged in the Form of Questions and Answers. Prepared Especially for Students of Medicine. By H. A. Hare, B. Sc., M. D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia; Physician to St. Agnes' Hospital, and to the Medical Dispensary of the Children's Hospital; Laureate of the Royal Academy of Medicine in Belgium, of the Medical Society of London, etc.; Secretary of the convention for the revision of the Pharmacopeia. 1890. Saunders' Question-Compends, No. 1. Third edition, thoroughly revised and enlarged by the addition of a series of handsome plate illustrations taken from the celebrated Icones Nervorum Capitis of Arnold. Philadelphia: W. B. Saunders, 913 Walnut street. 1891.

In this volume of question compends we find the subject of physiology concisely and accurately considered. It will be found an aid to the memory in mastering the subject, but should not be in any sense taken to supplant the general treatise or to prevent the efficient laboratory work in acquiring a knowledge of one of the fundamental departments of medicine. Dr. Hare has presented the subject in the best light possible for this particular form of literature.

The Surgical Treatment of Wounds and Obstruction of the Intestines. By Edward Martin, M. D., Instructor in Operative Surgery, University of Pennsylvania, Surgeon to the Howard Hospital, Assistant Surgeon to the University Hospital; and H. A. Hare, M. D., Professor of Therapeutics, Jefferson Medical College; Attending Physician to St. Agnes' Hospital. Fiske Fund Prize Dissertation. No. XL., 8vo, pp. 169. Philadelphia: W. B. Saunders. 1891. Price, cloth, $2.00 net.

The importance attaching to wounds and obstructions of the intestines makes it fitting and proper that a monograph should be prepared on these subjects, which shall consider them from both the medical and surgical sides of the question. Drs. Martin and Hare have presented such a monograph in the work under consideration, and it is one which deserves the careful study of physicians, who either practice on the one side or the other of the question. In this book, consisting of an introduction, fourteen chapters, and a table of cases, together with an index, will be found some of the most modern thought pertaining to the important sub-

jects considered, that commends it to the profession as an able exposition thereof.

A Compend of Human Physiology, Especially Adapted for the Use of Medical Students. By Albert P. Brubaker, M. D., Professor of Physiology, Pennsylvania College of Dental Surgery; Demonstrator of Physiology in Jefferson Medical College, Philadelphia. Sixth edition; Revised and improved, with new illustrations. Quiz Compends No. 4. Philadelphia: P. Blakiston, Son & Co. 1891.

Considering the fact that Dr. Brubaker's little book has passed to its sixth edition, there is no question as to its having become a standard of its kind. It is as good a compilation of the subject as has yet appeared, and will, no doubt, command ready sale.

Three Thousand Questions on Medical Subjects, arranged for Self-Examination, with the proper references to standard works, in which the correct replies will be found. Philadelphia: P. Blakiston, Son & Co. 1891.

These questions have been admirably arranged with reference to the object desired to be attained. The frequent self-examination of a student may be very greatly systematized through a work of this kind, but we cannot see any essential reason why it should be applied to any special works or references. It is intended by the publishers to present the book gratis to any who will apply for it, enclosing ten cents for postage.

Modern Materia Medica for Pharmacists, Medical Men and Students. By H. Helbing, F. C. S. Second enlarged edition. Cloth, 115 pages, 75 cents. Published by the *British and Colonial Druggist*. London: Lehn & Fink, New York, sole agents for the United States.

This little work, intended as a help to pharmacists and medical men, is the first detailed scientific treatise on new remedies published in the English language. It not only elaborates fully upon the constitution, methods of preparation, processes for identification and testing of the various substances, but gives valuable hints as to the most approved methods of prescribing and dispensing these various synthetic remedies. A valuable appendix, including tables of doses, melting and boiling points, and solubilities, is added.

The author has given us a very valuable work, and one which will be thoroughly appreciated by professional men. We recommend it most heartily to the busy pharmacist and physician.

J. A. M.

BOOKS AND PAMPHLETS RECEIVED.

International Clinics : A Quarterly of Clinical Lectures on Medicine, Surgery, Gynecology, Pediatrics, Neurology, Dermatology, Laryngology, Ophthalmology, and Otology. By Professors and Lecturers in the leading Medical Colleges of the United States, Great Britain, and Canada. Edited by John M. Keating, M. D., Philadelphia, Consulting Physician for the Diseases of Women to St. Agnes' Hospital, Philadelphia ; Editor Cyclopedia of the Diseases of Children.—J. P. Crozer Griffith, M. D., Philadelphia, Clinical Professor of Diseases of Children in the University of Pennsylvania ; Professor of Clinical Medicine in the Philadelphia Polyclinic.—J. Mitchell Bruce, M. D., F. R. C. P., London, England, Physician and Lecturer on Therapeutics at the Charing Cross Hospital, and David W. Finlay, M.D., F.R.C.P., London, England, Physician to the Middlesex Hospital, and to the Royal Hospital for the Diseases of the Chest ; Lecturer on Clinical Medicine in the Middlesex Hospital Medical School. July, 1891. Philadelphia : J. B. Lippincott Company. 1891.

Transactions of the Association of American Physicians. Sixth session, held at Washington, D. C., September 22, 23, 24, and 25, 1891. Volume VI. Philadelphia: Printed for the Association. 1891.

The Physician as a Business Man ; or, How to Obtain the Best Practical Results in the Practice of Medicine. By J. J. Taylor, M. D. Philadelphia : *The Medical World*, 1520 Chesnut St. 1891.

A Manual of Hypodermatic Medication : The Treatment of Diseases by the Hypodermic or Subcutaneous Method. By Roberts Bartholow, A. M., M. D., LL. D., Emeritus Professor of Materia Medica, General Therapeutics and Hygiene in the Jefferson College of Philadelphia ; Honorary Fellow of the Royal Society of Edinburgh ; Honorary Member of the Société Medico-Practique de Paris ; Fellow of the College of Physicians of Philadelphia ; Member of the American Philosophical Society ; Fellow of the Medico-Chirurgical Faculty of Maryland ; Honorary Member of the various States and local Societies ; Author of a Treatise on the Practice of Medicine ; of a Treatise on Materia Medica and Therapeutics ; of a Manual of Medical Electricity, etc., etc. Fifth edition, revised and enlarged. Philadelphia : J. B. Lippincott Company. London : 10 Henrietta street, Covent Garden. 1891.

History of the Circumcision from the Earliest Time to the Present. Moral and Physical Reasons for its Performance, with a History of Eunichism, Hermaphrodism, etc., and of the Different Operations Practiced upon the Prepuce. By P. C. Remondino, M. D. (Jefferson), Member of the American Medical Association ; of the American Public Health Association ; of the San Diego County Medical Society ; of the State Board of Health of California, and of the Board of Health of the City of San Diego ; Vice-President of the California Medical Society, and of the Southern California Medical Society, etc. Philadelphia and London : F. A. Davis. 1891.

Saunders' Pocket Medical Formulary, with an Appendix, containing Posological Table, Formulæ and Doses for Hypodermic Medication ; Poisons and their Antidotes ; Diameters of the Female Pelvis and Fetal Head ; Diet List for Various Diseases ; Obstetrical Table ; Materials and Drugs used in Antiseptic Surgery, etc. By William M. Powell, M. D., author of Essentials of Diseases of Children ; one of the Associ-

ate Editors of the Annual of the Universal Medical Sciences; Attending Physician to the Children's Seashore House for Invalid Children, and the Mercer House for Invalid Women, at Atlantic City, N. J.; Member of the Philadelphia Pathological Society. Formerly Instructor of Physical Diagnosis in University of Pennsylvania; Attending Physician to the Children's Clinic at the University of St. Clement's Hospital; Chief of the Medical Clinic of the Philadelphia Polyclinic. Philadelphia: W. B. Saunders, 913 Walnut street. 1891.

Transactions of the Ophthalmological Section of the American Medical Association at the Forty-second Meeting, held at Washington, D. C., May 5 to 8, 1891.

A Treatise on Practical Anatomy for Students of Anatomy and Surgery. By Henry C. Boenning, M. D., Lecturer on Anatomy and Surgery in the Philadelphia School of Anatomy; Demonstrator of Anatomy in the Medico-Chirurgical College; Demonstrator of Anatomy in the Philadelphia Dental College; Lecturer on Disease of the Rectum in the Medico-Chirurgical College, etc. Illustrated with 198 wood engravings. Philadelphia and London: F. A. Davis, Publisher. 1891.

Manual of Physical Diagnosis, for the Use of Students and Physicians. By James Tyson, M. D., Professor of Clinical Medicine in the University of Pennsylvania, and Physician to the University Hospital; Fellow of the College of Physicians of Philadelphia; Member of the Association of American Physicians, etc. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut street. 1891.

A Manual of Venereal Diseases: Being an Epitome of the Most Approved Treatment. By Everett M. Culver, A. M., M. D., Pathologist and Assistant Surgeon Manhattan Hospital of New York City; Member of the American Association of Andrology and Syphilology, and late of the Department of Venereal Diseases of the Vanderbilt Clinic; and James R. Hayden, M. D., Chief of Clinic Venereal Department of Vanderbilt Clinic, College of Physicians and Surgeons, New York. With illustrations. Philadelphia: Lea Brothers & Co. 1891.

A Practical Treatise on the Diseases of the Ear, including a Sketch of Aural Anatomy and Physiology. By D. B. St. John Roosa, M. D., LL. D., Professor of the Diseases of the Eye and Ear in the New York Post-Graduate Medical School, and President of the Faculty; Surgeon to the Manhattan Eye and Ear Hospital; Consulting Surgeon to the Brooklyn Eye and Ear Hospital; formerly Professor of Ophthalmology in the University of the City of New York, and of Diseases of the Eye and Ear in the University of Vermont; formerly President of the Medical Society of the State of New York, etc., etc. Seventh revised edition. New York: William Wood & Co. 1891.

Age of the Domestic Animals. Being a Complete Treatise on the Dentition of the Horse, Ox, Sheep, Hog, and Dog, and on the Various Means of Determining the Age of these Animals. By Rush Shippen Huidekoper, M. D., Veterinarian (Alford, France); Professor of Sanitary Medicine and Veterinary Jurisprudence American Veterinary College, New York; Lieutenant-Colonel and Surgeon-in-Chief National Guard of Pennsylvania; Fellow of the College of Physicians, Philadelphia; Honorary Fellow Royal College of Veterinary Surgeons, London; late Dean of the Veterinary Department, University of Pennsylvania, etc. Illustrated with 200 engravings. Philadelphia and London: F. A. Davis, Publisher. 1891.

A B C of the Swedish System of Educational Gymnastics. A Practical Hand-Book for School Teachers and the Home. By Hartvig Nissen, Instructor of Physical Training in the Public Schools of Boston, Mass. ; Instructor of Swedish and German Gymnastics at Harvard University's Summer School, 1891 ; formerly Instructor of Physical Culture at the Catholic University, Washington, D. C., etc., etc. With seventy-seven illustrations. Philadelphia and London : F. A. Davis, Publisher. 1891.

The Supreme Passions of Man; or, The Origin, Causes, and the Tendencies of the Passions of the Flesh. Setting Forth the Results of Scientific Inquiries into the Appetites of Mankind, and the Passions which they Excite. A Study of the Crimes of the Flesh, and the Efforts of Christianity to Maintain Purity. An Essay on the True Causes of Drunkenness, and the Only Way to Prevent this Evil. Observations on the Relation of Vice to the Laws of Nations, and Existing Educational Systems. By Paul Paquin, M. D., late Professor of Comparative Medicine, and Director of the Bacteriological Laboratory, Missouri State University ; Member of the American Public Health Association ; Member of the American Medical Association ; Member of the American Society of Microscopists ; Member of the Missouri State Medical Association, etc., etc., Editor of the *Bacteriological World ;* Director of the Laboratory of Hygiene, Battle Creek, Mich. Published by the Little Blue Book Co., Battle Creek, Mich.

Therapeutics of Diphtheria. By Joseph Burghardt, Practising Physician in Vienna. From a lecture delivered at the meeting of the Council of Vienna Physicians, April 8, 1889. Translated by Charles Raettig. Translation authorized by the lecturer. New York : J. H. Vail & Co. 1891.

A Vegetable Plate ; also a New Technique in Intestinal Anastomosis. By Robert H. M. Dawbarn, M. D., Professor of Surgical Anatomy and Operative Surgery New York Polyclinic.

Some Clinical Features of Stone in the Bladder. By L. Bolton Bangs, M. D., Surgeon to St. Luke's and Charity Hospitals ; Professor of Genito-Urinary and Venereal Diseases in the New York Post-Graduate Medical School. Reprint : *The New York Medical Journal*, August 15, 1891.

The Third Series of One Hundred Consecutive Operations, Showing the Results of Antiseptic Methods of Work. By Robert T. Morris, M. D., New York City, Instructor of Surgery at the Post-Graduate Medical School, New York City. Reprint : *New England Medical Monthly.* Danbury, Conn.: The Danbury Medical Printing Co. 1891.

An Attempt to Show What New Jersey Surgeons Have Done in Abdominal Surgery. By Edward J. Ill, M. D., of Newark, N. J., Fellow of the American Association of Obstetricians and Gynecologists ; Surgeon to Woman's Hospital ; Gynecologist to St. Barnebas' Hospital ; Consulting Surgeon to the German Hospital, etc. Read before the Medical Society of the State of New Jersey. Newark, N. J.: L. J. Hardham, printer and binder, 243 and 245 Market street.

Is a Child Viable at Six and a Half Months ? By Llewllyn Eliot, M. D., Washington, D. C. Reprint : *The Virginia Medical Monthly*, November, 1891.

Obituary.[1]

Dr. Simeon Tucker Clark, of Lockport, died in that city Thursday evening, December 24, 1891, of paralysis. Dr. Clark was attending physician to the Niagara County Almshouse, and while paying one of his accustomed visits to that institution, a day or two before his death, was stricken with the malady which finally proved fatal.

He was a member of the several County and State Medical Societies, and Professor of Medical Jurisprudence in the Medical Department of Niagara University. He had attained to eminence in his profession, and his poetical talents were of a high order. He acquired fame as an alienist, and his services were often sought in the courts as a medical expert in mental and criminal cases.

He leaves a widow, a son, and a daughter, to mourn his untimely death, and a profession that will everywhere unite in sympathy with those who have suffered this bereavement.

Dr. William Chace, of Mayville, Chautauqua County, died at his residence on the morning of Sunday, December 27th, aged about sixty years. For a third of a century Dr. Chace had been prominent in his profession in Western New York, attaining to an eminence far in advance of many in the region of his practice. He was a member of the several medical organizations of his County and State, and also curator of the medical department in the University of Buffalo.

He leaves a widow and four sons, who receive the sympathy of friends and neighbors, as well as that of a liberal profession, in their sudden and trying bereavement.

Personal.— Dr. Daniel Lewis, President of the New York Physicians' Mutual Aid Association, visited Buffalo in the latter days of December, on business connected with the useful institution which is receiving his most faithful and energetic service. During the two days he spent here much was accomplished in infusing a spirit of enthusiasm among the physicians of Buffalo, regarding this most noble charity. We hope to chronicle in a future number of the Journal some of the results of Dr. Lewis's timely visit.

1. These notices were received too late to appear in their proper place.—[*Printer.*]

Miscellany.

We call the attention of our readers to Messrs. John Wyeth & Brother's new advertisement, which appears in this number, relating to their compressed tablets of new remedies (antipyretics) for influenza, neuralgia, headache, etc. Their great convenience for administration commends them to the profession.

Always at the Front.—We have received a copy of the handsomely illustrated prospectus for 1892, issued by the *Detroit Free Press*. The achievements of this famous paper in the past have been great, but if its promises for the future are to be fulfilled—and there certainly is no reason to expect the contrary—the *Detroit Free Press* will, in 1892, be, as its publishers confidently claim, the most entertaining and instructive paper published, giving additional pleasure to its thousands of old subscribers, and fresh enjoyment to the many thousand new ones that its merits deserve. Its list of contributors for 1892 includes many of the most famous names in American literary and public life, and most of the articles to be published are of unusual importance and interest, presenting a splendid array of valuable features in addition to the inimitable work done by its own staff of bright and famous writers.

The publishers of *The Free Press* will mail copies of the paper and prospectus to all applicants.

Happy and content is a home with "The Rochester; a lamp with the light of the morning. Catalogues, write Rochester Lamp Co., New York.

Current Medical Literature.—In the next number of the *Sanitary Era* will be commenced a regular list of the principal contents of the medical journals for the month, which, it is hoped, will be valuable to every physician as well as to professional exchanges themselves. Few can afford, and still fewer could find time to explore, the large number of such periodicals, each of which, from time to time, contains something which the individual practitioner or student of medicine would be very sorry to miss, and yet nearly sure to miss, without such an index as is proposed. Sample copies will be sent on request. The editor would also like to be advised how far an extension of the index to foreign periodicals might probably be encouraged by subscriptions to the paper.

Buffalo Medical and Surgical Journal

Vol. XXXI. FEBRUARY, 1892. No. 7.

Original Communications.

TRANSVERSE PRESENTATIONS.—HISTORY OF A CASE WITH A NEW METHOD OF TREATMENT.

By EUGENE EVERETT BARNUM, A. M., M. D.,

Lancaster, C. H., Virginia

Ex-President of the Orleans County (N. Y.) Medical Society, Member of the Central New York Medical Society; Member of the Virginia State Medical Society, etc.

Of all the cases which a physician is called upon to attend, there are few which give him more trouble, or which cause greater anxiety, than do those of transverse presentations.

Such complications, at all times, are serious; but their gravity is far greater if the patient has been left without medical treatment until convulsions, or threatened collapse, or the unexpected appearance of a hand protruding from the vulva give warning, in terms too plain to be misunderstood, that all is not right, and cause the friends to send a messenger in great haste for a physician.

To the physician who then comes in only — almost — "at the death," a condition is presented, the gravity of which all authorities admit. All agree that delivery by the unaided power of nature is the very rare exception and not the common rule.

Playfair says: "Intervention on the part of the accoucheur is, therefore, absolutely essential, and the safety of both mother and child depends upon the early detection of the abnormal position of the fetus; for the necessary treatment which is comparatively easy and safe before labor has been long in progress, becomes most difficult and hazardous if there has been much delay."

Referring to Churchill's statistics, in speaking of the prognosis and treatment of these cases, Playfair also says:

Shoulder presentations occur about once in 260 cases,—that is, only slightly less frequently than those of the face. The prognosis, both to mother and child, is much more unfavorable, for he estimates that out of

235 cases, one in nine of the mothers and half of the children were lost. The prognosis in each individual case will, of course, vary much with the period of delivery, of which the malposition is recognized. If detected early, interference is easy, and the prognosis ought to be good ; whereas, there are few obstetric difficulties more trying than a case of shoulder presentation in which the necessary treatment has been delayed until the presenting part has been tightly joined into the cavity of the pelvis.

In speaking of the mechanism of this presentation, he says: "It is hardly proper to talk of the mechanism of shoulder presentations since, if left unassisted, they almost invariably lead to the gravest consequences."

Dr. Charpentier, in Hood's Cyclopedia of Obstetrics and Gynecology, gives the following under the head of prognosis of this presentation :

The prognosis of delivery by the trunk is always very serious. Besides, we must endeavor in every case to recognize this presentation before labor ; for, as we will see, we can transpose it into a vertex presentation by external manipulations. But if labor has commenced and external version is impossible, spontaneous delivery should never be waited for and recourse must be had to version by internal manipulation, which, however, is not always devoid of danger for mother and fetus. Hence, the prognosis is always grave in proportion to the time elapsed since the outset of labor, as the difficulties of intervention increase *pari passu*.

In the article on Labor, in the Reference Hand-book of the Medical Sciences, we find : "The prognosis is not necessarily bad if the treatment be early and judicious. But otherwise the maternal mortality is considerable and the fetal still greater ; while in long neglected cases it is well nigh impossible to save the child's life, and the mother's is greatly imperiled . . . When the arm has remained prolapsed for hours, and the uterus has contracted tetanically about it, the waters having entirely drained away, reversion may be impossible. Then, if our examination reveals no tendency toward spontaneous evolution, we have to choose only between Cesarean section and embryotomy."

Other authorities, which I have consulted, give the same testimony. All agree that an attempt should be made to perform reversion, but all admit that the attempt usually fails, unless it is made early in the labor. When this fails, the only methods of treatment recommended are Cesarean section or embryotomy. In the former case the danger to the mother is great, while the latter operation

necessarily destroys the child and is far from being without danger to the mother.

I believe that in cases of such gravity any method of treatment is worthy of a trial, if it holds out a prospect of reducing the danger either to the mother or to the child. Therefore, I give the following history of a case which occurred in my practice.

On Thursday, March 27, 1890, I was called to assist in a case of transverse presentation.

From the attending physician, Dr. Thomas D. Eubank, I obtained the following history:

The patient was Margaret Wood, colored, twenty-seven years of age, the mother of three children. Her former pregnancies and labors were normal. This, her fourth, pregnancy was without incident until the middle of her eighth month, when "she fell out of her house-door, face foremost, and felt she had done herself great injury." Her labor began at term, two weeks later. Pains began about 3 P. M. Wednesday, March 26th. The colored midwife was summoned and she came at once. Pains continued all night. Early the next morning the "waters broke and a hand was thrust forward with the pain that broke the waters."

After waiting several hours – the patient meantime having had several convulsions – Dr. Eubank was called. He saw the patient about 3 P. M., – twenty-four hours after the beginning of labor. Upon examination he found the right shoulder presenting with the hand protruding at the vulva. After vainly trying to perform version he asked for assistance, when I was sent for. I arrived at the bedside of the patient about 7 P. M., and found the arm prolapsed as far as the elbow, the waters drained away, the uterus in a state of tonic contraction, caused (to some extent at least) by the ergot which the midwife had given, and the patient discouraged and nearly exhausted.

We renewed the attempt to perform version and again failed, on account of the firmness with which the shoulder and side of the head were jammed down upon, or just within, the pelvic brim. All attempts to replace the prolapsed arm also failed, on account of the tetanic contraction of the uterus upon its contents.

(In this connection I can state that the force with which the shoulder was crowded into the superior strait, is shown by the fact that several months elapsed before the child could move that arm as freely as its fellow was moved.)

Version having failed, our authorities gave us our choice of two methods of treatment - Cesarean section and embryotomy, – neither of which was practicable in this case. It was believed that the former operation would almost necessarily cause the death of the mother. Instruments for the latter operation were not at hand and could not be procured

in time to be of service. In this emergency I determined to try a method which, so far as I know, never has been recommended in the treatment of transverse presentations.

Our failure to perform version was due, as has been stated, to the firmness with which the presenting part was held upon or just within the pelvic brim. How to overcome this difficulty was the problem to be solved. Remembering that my friend, Dr. W. W. Potter, of Buffalo, had met with very gratifying results, in certain cases of gynecological practice, by calling the force of gravity to his aid; and remembering Dr. Playfair's treatment of prolapse of the cord, by calling the same force to his assistance, I decided to make use of this force.

The woman was placed in the knee-chest position upon the bed, when we again attempted to push back the fetus, hoping either to replace the arm and get a vertex presentation, or else to be able to perform podalic version; but so firmly was the fetus held in position that we again failed. I next brought the patient on her knees, to the edge of the bed, with a strong assistance at each side. Her head was slowly lowered until her position was nearly inverted—her head almost touching the floor. Then compelling her to breathe rapidly, to prevent her "bearing down" involuntarily during her pains, we soon began to feel the gradual withdrawal of the fetus from the superior strait. Within a very few minutes—probably not more than five—we were able to replace the arm. With the next pain the head presented by spontaneous version. The patient was then directed to "bear down hard," and was placed in bed, the descent of the arm being prevented by means of a finger in the vagina.

Labor proceeded rapidly, and within fifteen or twenty minutes the child was born *alive*.

From a careful study of this case, with the aid of all the obstetric literature that was within my reach, I have formed the following conclusions:

I. This was a typical case of transverse presentation when first seen by my friend, Dr. Eubank, twenty-four hours after the beginning of the labor, and many hours after the hand "was born."

II. In that late stage of the labor, version by the usual methods was a physical impossibility; embryotomy was not possible, on account of the absence of the necessary instruments, and Cesarean section would only hasten the death of the mother.

III. By the method of treatment employed by me the presenting part was removed from the superior strait, the malposition was corrected and the child was born *alive*,—the whole time from the beginning of the treatment to the birth of the child not exceeding thirty minutes.

IV. The proposed method of treatment does not necessitate the exposure of the patient, and if the changes of position are made slowly and carefully, very little, if any, distress or harm will be experienced by her.

V. Special complications may call for special treatment,—for instance, convulsions might require the use of chloroform, etc.

VI. I believe that this method will be found useful in performing version by external manipulation, by internal manipulation or by both combined, and in many cases, as in mine, it will give nature a chance to correct the presentation by spontaneous version.

VII. A failure of this method will not prevent or complicate treatment of Cesarean section or embryotomy.

Whether this method of treating transverse presentations is, as I believe, original with me or not, I can bear testimony to its efficacy in the only case of the kind which ever occurred in my practice.

CLINICAL CONTRIBUTIONS TO BRAIN SURGERY.[1]

By JOHN B. ROBERTS, M. D.,

Professor of Anatomy and Surgery in the Philadelphia Polyclinic; Professor of Surgery in the Woman's Medical College of Pennsylvania.

In 1885[2] I took strong ground in favor of more active surgical interference in injuries and diseases of the cranium and brain. At that time the views advocated by me were looked upon as being too radical, and were quite vigorously opposed by many prominent surgeons of this country. Since that date there has been developed an unprecedented activity in the operative treatment of cranial and intracranial lesions, which, even in my opinion, has been too extreme. It is, perhaps, not difficult to understand this unscientific and unreasonable adoption of what might be called a surgical fashion. It is to be regretted that the enthusiasm created by success impels some men to interfere surgically in nearly all cases that come into their hands, without a judicious study of each particular patient. That unrestrained mania for operating which has made abdominal surgery almost a by-word has, it seems to me, entered into the domain of cerebral surgery. It is just as much a part of scientific surgery to abstain from operating unnecessarily, as it is to combat vigorously the unreasonable conservatism of those who

1. Read at the stated meeting of the Philadelphia County Medical Society, November 25, 1891.

2. The Field and Limitation of the Operative Surgery of the Human Brain. *Annals of Surgery*. July and August, 1885.

will not see the force of anatomical, surgical, and statistical evidence. Fortunately for the patients, a healthy reaction is at last taking place, and surgeons are not now removing brain centers and tunnelling the brain in search of abscesses and tumors in quite as enthusiastic a manner as they were a couple of years ago. That such lesions should be promptly attacked surgically is unquestioned, but this should be done only after a thorough survey of the conditions and a judicial estimate of the gain that will possibly arise. The experimental character of many operations upon the brain in recent years, has been almost as patent as in vivisectal operations done with an avowed experimental purpose. Death on the operating table and unsuccessful operations have at length begun to stay the hands of these over-enthusiastic surgeons ; and there is now ground for hope that cerebral surgery will, ere long, become less reckless.

My personal opinions are very much what they were in 1885 ; indeed, the advances in diagnosis and the improvements in operative methods have made me even more sure of the correctness of the conclusions then advanced. I cannot, however, bring myself to approve of the reckless way in which human life is often threatened by operations which hold out scarcely a ray of hope to the helpless patient. The rapidity of healing in aseptic wounds and the tolerance of the brain under operative attack, do not justify hasty resort to intracranial surgery simply because the patient or his family are submissive under the persuasive eloquence of the would-be operator.

I desire tonight to report a few cases which have a practical bearing on some of the fundamental principles of cerebral surgery, and I hope they will serve as a means of bringing out the views of others in this interesting field.

Case I. *Trephining for cortical epilepsy apparently the result of traumatism ; improvement, followed by death in five weeks.*—A child, twenty-nine months old, had sixteen months previously received a fall, and on the second day after the accident was seized with convulsions. Four months before he had been struck on the head by a falling clock, but no special symptoms followed this mishap. Since the second injury he had had spasmodic seizures occurring at frequent intervals during nearly every day. He dragged the left leg a little, did not seem bright, and was still unable to talk. There was a slight tendency to draw up the mouth on the left side, and also an inclination to turn the head and body to the left. When his attention was directed to bright objects he would, apparently, try to look at them, but his eyes usually turned to

the left. His hearing seemed to be dull, but so far as could be determined the cutaneous sensibility was unimpaired. No changes were found by ophthalmoscopic examination.

Dr. Charles K. Mills, who referred the patient to me, placed the child under observation in order to detect, if possible, the exact character of the spasms. He was watched carefully in several seizures. Usually he squealed at the beginning of the paroxysm and his face had a vacant look. The spasm began with a lifting movement of the entire body, as if with the muscles of the trunk, much like a sudden effort to rise from a recumbent to a sitting position. About the same time, as nearly as could be judged, the eyes and head turned to the left. The eyes did not keep to the left, but oscillated with the jerking movements of the body; the head, however, continually turned to the left. The left leg and arm were spastic in slight flexion and were lifted up and projected outward and forward. The limbs on the right side were flaccid, but were projected forward and upward with the jerking movements apparently communicated from the trunk and the left limbs.

Another description of the attacks records that the child awakened suddenly from sleep with a toss of the body, as if badly frightened, with the head and eyes at once turning to the left. The left arm was extended forward and upward stiff and rigid, with the thumb and little finger pointing backward, the other fingers being slightly flexed. Both legs were also tossed upward in the air, the left more projected than the right. His body was lifted up and down during the attacks.

It was difficult to determine any signal symptom or serial order of movements. The spasm was both tonic and clonic, and certainly most marked in the limbs and face of the left side. The movements of the leg and arm were those of projection and protraction, and were rather movements from the shoulder and hip than from and in the distal portions of the limbs. The movements of the head, trunk, face, and limbs were often nearly coincident, but the conjugation of the head and eyes seemed certainly to be most commonly the initial movement.

The above description is taken from a former report of the case.[1]

Dr. Mills thought that the symptoms seemed to point to a lesion of the area for conjugate deviation of the head and eyes, and certain associated movements of the trunk, thigh, and arm. It was, therefore, determined to trephine over the posterior portions of the first and second frontal convolutions.

After encircling the head with a rubber bandage to prevent hemorrhage from the scalp, I made an opening with an inch and a half trephine placed one and a quarter inches in front of the fissure of Rolando and a little to the right of the median line. Behind and below the opening so made I cut out another button of bone with a one and a quarter inch

1 *Polyclinic*, April, 1889, p. 200

trephine. The spurs of bone between the two holes were cut away with forceps. One point of the aura was abnormal in thickness and rather more adherent than normal. This condition did not seem to be caused by a Pacchionian body.

A flap of the dura was raised. The pia mater was very edematous, so that it could be pitted with the finger. A thin, yellowish-white membrane was found lying loosely upon the pia-archnoid and had probably separated from the dura when the flap of that membrane was raised. This abnormal membrane was removed. Small electrodes applied to the convolutions failed to induce contraction of the left arm. This electrical test was repeated, but failed to give results, though no antiseptic solution had come in contact with the brain tissue before the electrodes were used. Incisions in the pia allowed the serum which caused the edema to escape. When the convolutions were thus clearly exposed, there was no evidence of change in their structure or of any subjacent lesion. The dural flap was then sutured in position, and the portions of bone, which had been kept in antiseptic solution at a temperature of 105°, were replaced. Some catgut threads were laid beneath the buttons of bone and carried through the incision in the scalp to give drainage.

The child was under my observation for nineteen days, during which time there were only three epileptiform attacks and these were within two or three days after the operation. They were all slight and would scarcely have been recognized as pathological symptoms, if the previous severe attacks had not formed part of the clinical history. A large amount of cerebro-spinal fluid escaped for several days through the opening left by the catgut drain, which was removed a day or two after the operation, and also through a small hole in the line of incision which had not healed by first intention as had the rest of the wound.

Bromide of potassium, calomel, and small amounts of alcoholic stimulants were given to the child during the after-treatment.

When he was discharged from under my immediate care his general condition was good, temperature normal, and there had been no escape of cerebro-spinal fluid for three days. The two small openings in the scalp were covered with small crusts.

Two weeks later the child died, but the history of the intervening period is unknown. I heard only indirectly of his death. No post-mortem examination was made, but indefinite information has come to my knowledge, which leads me to believe that suppuration under the scalp occurred.

This case is one of a class in which there is a great temptation to operate in hope of finding some removable lesion of the cortical centers. The findings are usually negative; and the results only temporarily satisfactory, even when the patient entirely recovers

from the lesions incident to the operation. Unless the localizing symptoms and signs are more definite than in this instance, I think that in similar cases I shall hereafter be almost inclined to avoid operative interference. This provisional conclusion has been reached by a consideration of cases in the treatment of which I have been concerned, or with whose results I am familiar.

CASE II. *Traumatic epilepsy resulting from unsuspected fracture: trephining with discovery of an irregular projection of bone on the interior of the cranium.*—A man, J. H., aged thirty-four years, while working as a puddler, about eight years ago, received an injury on the left side of the head by being caught between an iron lever of a furnace and a brick wall. He was treated by no physician, and only lost about two days from his work, although the injured region was poulticed by him, and was the seat of a discharge for four or five months. No portion of bone came from the wound, and there were no special symptoms.

Several years ago he had venereal sores upon the penis, but no suppurating inguinal glands or syphilitic developments. Chills and fever, several years ago, constituted the only illness from which he suffered.

An examination of his head, after shaving, revealed several insignificant scars, and just above the zygoma on the left side, a half inch in front of the auricle, a depressed cicatrix sufficiently deep to hold the tip of the little finger. This was the scar left by the injury received eight or nine years ago. The cicatrix involved the temporal muscle, as was seen by the dragging of the skin over the scar during mastication. There was no evidence of depression of the skull in any other part of the cranium, and this depression did not seem to involve the underlying bone. His intelligence was good, but the patient said that he did not remember as well as he could a few years ago, and that at times his eyesight was not good. He shows at times a little mental deterioration. An ophthalmoscopic examination of the eyes gave negative results.

The patient states that about two and a half years ago he had an epileptic fit after working in a hay-field on a hot day, and that since that time he has had marked seizures about every six weeks, with lesser attacks more frequently. He has but one epileptic fit at a time, from which he rapidly recovers, and is soon able to walk about. After such attacks he feels weak for some time. For several years he has had severe headache, not confined to any one portion of the head, and just before the epileptic seizure he feels a jerking sensation on the right side of the nose. He complains that his general health has deteriorated, but there is no apparent loss of flesh.

On the 26th of September of the present year (1891), I turned up a

large flap of the scalp and found, after cutting through the temporal muscle, a depression in the skull one inch in length and three-eighths of an inch in width. This fracture was a surprise to me because of the history of the case and the situation of the injury over the thick belly of the temporal muscle. A three-quarter inch aeptic trephine was applied above and behind the depression. This cut through the bone with some difficulty, because the upper portion of the disc was much thicker than the lower part. Unfortunately my segment trephine had been forgotten, or this part of the operation could have been more expeditiously performed. Thinking I had cut entirely through the skull, I endeavored to pry out the disk, but removed simply the outer table of the button; I found that between it and the internal surface there was a portion of fibrous tissue entangled. It was probably this portion of tissue entangled in the bony cicatrix as a result of the fracture at the time of the injury, that enabled me to lift out so readily the upper surface of the bony disk. The entangled tissue was doubtless pericranium. Removal of the interior table of the disc revealed below and in front of the opening a teat-like elevation projecting from the lower surface of the skull and pressing upon the dura. This elevation was about one-fourth of an inch higher than the general surface of the interior table, and was the apex of an irregular elevation due to consolidation of a number of comminuted fragments of the inner table. The irregular lines of fracture, with the fragments displaced in varying degrees, are shown on the button removed and the rest of the bone subsequently cut out with gnawing forceps.

The specimen shows this condition very satisfactorily, though somewhat mutilated by the gnawing forceps with which the adjacent bone was removed after the original button was taken out. The depth of the skull wound and the thickness of the temporal muscle made it rather difficult to operate neatly, and my desire to get rid of the portion of bone pressing upon the dura, without prolonging the operation or increasing its severity, caused me to sacrifice the specimen in the interest of the patient. The dura was not opened, threads of catgut were used for drainage, and a dry sublimate dressing was applied.

The following day the wound was found to be healing by first intention, and the drainage threads were removed. Bromide of potassium and chloral were given for two nights; and then twenty grains of bromide of potassium three times a day were ordered as a continuous treatment.

On the third day after the operation the patient had a sensation of twitching at the side of the nose similar to that which formerly preceded the epileptic seizures; but he had no fit. The wound healed by first intention, the temperature never rose above 99.6°, and on the eleventh day after the operation the patient was sent to his home in the center of the State. He felt exceedingly well after the operation and

expressed his satisfaction at the improvement of his condition. I suggested that the bromide treatment be continued by his physician, Dr. J. P. McCleery, under the idea that removal of the surgical cause of epilepsy should be looked upon as only a part of the treatment. I believe that in all such cases internal treatment should be combined with surgical procedures, and that the epileptic habit should be controlled by a prolonged course of bromides after the mechanical cause has been removed.

Seven and a half weeks after operation his physician reported that

Fig. 1.

Outer surface of fractured cranium showing lambdoidal suture, point where trephine was applied, and small indentation looking like entrance of a vein made by the blow.

Fig. 2

Inner surface of fractured cranium, showing cut made by trephine and large area of inner table driven inward under the small external indentation. The trephine has not cut entirely through the bone where the inner table is driven inward.

he had suffered no return of his epilepsy and was about to resume his work. As far as it goes, this statement is gratifying, but much more time must elapse before we can feel sure of a cure having been effected. The lesion is certainly one of those in which trephining ought to be eminently beneficial. Punctured fracture such as this should always be subjected to immediate trephining at the time of injury.

Above is given a representation of the external and internal appearance of the skull in a case trephined by me some years ago. There was a small scalp-wound through which I could, with my

finger tip, feel what I thought was rough bone. I found by incision that the roughness was due to an unusually irregular lambdoidal suture with Wormian bones; and that the only bony lesion caused by the blow received from the pitcher, with which the patient was struck, was a small dent looking like the opening for the entrance of a vein. The character of the vulnerating force, however, induced me to trephine. The removal of the trephine button and the insertion of a probe between the dura and the cranium discovered nothing except a small fissure on the inner surface of the disc. Death occurred within a short time from alcoholic delirium; and the autopsy revealed a T-shaped fracture of the inner table with a shelf-like detachment of quite an area of bone. If this patient had lived he would probably have had secondary epilepsy, as occurred in the case just reported. The urgent necessity of primary trephining in such punctured fractures, even where no symptoms are present, is fully illustrated by these cases. The many deaths from cerebral abscess and other inflammatory processes, following the receipt of punctured fracture of the cranium, long ago justified the surgical conclusion that trephining in such injuries should not be delayed until the advent of symptoms of encephalic inflammation. The epilepsies resulting in cases which have escaped the immediate dangers of encephalitis, add another argument to the wisdom of immediate operation in punctured fractures.

Case III. *Secondary trephining for traumatic epilepsy; death from aseptic cerebral inflammation.*—In June, 1891, I operated upon a man, J. T., aged twenty-eight, with the following history:

While working in a mine he had been struck upon the head with a huge mass of coal and rendered senseless. The attending physician, Dr. James D. Garvey, found a fracture of the skull, and upon the day of the injury removed a portion of the bone. According to the patient's statement he recognized no one for fourteen days, and was, therefore, probably unconscious during that time.

After consciousness returned his left arm was paralysed, but gradually regained power. Eight months afterward he had an epileptic seizure, and has had epileptic paroxysms at irregular intervals ever since. He is aware of the approach of a convulsion by nausea, dizziness and disorder of vision. Occasionally he has time, after the premonitory symptoms, to sit down before the fit occurs. He thinks that he ordinarily falls in the convulsion, but he does not bite his tongue at such times, though he froths at the mouth and grinds his teeth. The attacks have occurred as often as one or two in a day, but he has gone as long as four months without a paroxysm. The ophthalmoscopic examination reveals a normal fundus, clear media, and hyperopic refrac-

tion. He is unable to say in what part of the body the muscular spasm begins.

A large triangular depression is seen upon the right side of the head, the upper margin or base of which is one and three-quarter inches to the right of the median line and almost parallel to it. The apex of the triangle points downward and forward towards the ear. The anterior margin of the depression is near or a little behind the fissure of Rolando, and the center of the depression is over the superior parietal convolution, or in that vicinity. The deepest portion of the depression is that near the middle line of the skull, at which part its depth is fully a half inch ; the edge of the depression at this point is almost vertical. The inferior and posterior borders are less abrupt. The angle, which I have called the apex of the depressed triangle, is about two inches above the ear, and a little behind a vertical line drawn upward from the ear. The margins of the depressed area form an equilateral triangle, each side of which is about one and one-quarter inches in length. There are a number of other scars on the head, one or two of which radiate from this depression. There is distinct weakness of the grasp of the left hand, but no marked difference in size of the hand or the arm. The patient complains of the left hand feeling differently from the right. There is no muscular contracture and no apparent change in the electrical reaction or in mensuration.

On account of the epileptic attacks in this case I determined to operate and remove any apparent cause of irritation. If nothing abnormal was found, I intended to remove the cicatricial tissue in the bony gap and also the bony margin of the opening in the skull. Accordingly, I made an elliptical flap in the scalp, which disclosed a triangular depression in the skull corresponding with the indentation seen externally. This was filled in with fibrous tissue, which I dissected out of the bottom of the depression. The bone was so thick that the gnawing forceps could not cut away the edges : hence, I used an aseptic trephine and removed a disc one inch in diameter from one corner. Subsequently I made four small holes along the edge of the depression with a half-inch trephine, and then was able to gnaw away the edges with gnawing forceps. The soft tissues were yellow, and pigmented in places with particles of carbon, evidently due to coal dust ground into the wound at the time of the accident.

Before the operation, pressure upon the scalp gave the sensation of a small cavity filled with air under the integument. It resembled the sensation experienced when a varicose vein is palpated. Removal of the skin over the gap in the cranium did not alter this tactile phenomenon. The yellow pigmented tissue, found as above mentioned, was not brain tissue ; and when cut through, disclosed what looked like the interior of an emptied cyst, because the inner surface of the tissue had a smooth, glistening surface. No fluid escaped or had escaped by

puncture. After having dissected away a considerable portion of this material, and having removed the edges of bone along the entire circumference of the bony opening, I reached normal brain tissue. Hemorrhage from the cerebral wound and from the periosteum was profuse. It seemed impossible to stop that which came from the brain and its membranes, which were fused together in an almost indistinguishable mass at the bottom of the deep hole. The triangular opening in the skull measured about two inches along each margin. The pulse became very feeble, counting 165 a minute. Prolongation of etherization and operation seemed unwise.

After unsuccessful attempts to stop the bleeding by ordinary methods, I concluded to grasp all the bleeding points with hemostatic forceps which should be left in the wound. This was done, and five forceps were left in the wound with their handles protruding. Iodoform powder was dusted upon the surface of the exposed brain and strips of iodoform gauze packed into the cavity. A few sutures were applied after the flap had been replaced; the gauze strips and hemostatic forceps projected from one corner of the wound. A voluminous dressing of iodoform gauze and cotton was then applied and the patient put to bed. Seven and one-half hours after the operation the dressings were saturated with bloody serum, and, therefore, in order to avoid sepsis, I determined to reapply them and to remove the hemostatic forceps at the same time. This was done carefully, the gauze withdrawn, and the wound redressed with a dry antiseptic dressing. In drawing out the strips of gauze, a little oozing of blood occurred, but this hemorrhage I did not think of sufficient importance to prevent my closing the whole wound with sutures and without drainage.

The next morning the patient showed great restlessness, but was in a condition of hebetude. He, however, made his wishes known when he desired to urinate. Bromide and chloral were given to control the restlessness.

On the second day respiration varied from 25 to 40 in a minute, and the temperature was 101°. During the day the patient's condition was fairly good, though he was difficult to control on account of his restlessness and irritation. The urine was passed unconsciously. A turpentine enema was given; bromide and chloral were continued. On the third day after the operation it was necessary to give the patient one-sixth of a grain of morphine hypodermatically, and to strap him in bed because of his tossing from side to side. During the day he became hoarse, and I discovered at the base of the right lung harsh rales, probably bronchitic. The temperature was now 101.6°, while his respiration was between 35 and 40.

On the fourth day after the operation the note is made that he slept after a hypodermic of morphine, one-sixth of a grain, and is quieter. Respiration 40 to 45. His breathing, however, was embarrassed and

harsh, somewhat of the Cheyne-Stokes's type. At 7 P. M. respiration was 50; temperature, 102°. The wound had been left undisturbed since the evening of the operation when the hemostatic forceps were removed. The rise in temperature and the patient's restlessness made me fear that there had been something amiss in my antiseptic precautions. I therefore determined to inspect the wound. Upon removing the dressing, I found the flap bulging and detected a feeling of fluctuation when my finger was put upon it. I expected to find pus under the flap, although the wound had healed by first intention. I tore open the union, but no evidence of pus existed; a soft aseptic clot of blood, however, lay under the flap. I removed the clot and explored the cranial cavity through the operation wound with my finger in search for pus. The cerebral tissue was disintegrated and soft, but no purulent collection was found. I moved my finger in various directions in the pultaceous mass, and finally, when my little finger was buried its entire length, came upon a hard mass at the bottom. This, I presume, was one of the great ganglia. The tissue overlaying this dart was almost fluid. There was no odor of decomposition nor evidence of pus. At the time of this exploration the patient was moribund, and I felt fully justified in these radical measures. Unless I found pus he was sure to die.

The dressings were re-applied; hypodermic injections of strychnine were given. Respiration gradually failed and the patient died the next morning, which was the fifth day after the operation.

It seems hardly possible that the fatal symptoms were due to pressure from such a small amount of hemorrhage under the flap, since there was much space by reason of so much bone having been cut away; and, moreover, the blood, if causing tension, would probably have readily escaped before the wound had united. I concluded, therefore, that death occurred from aseptic cerebral inflammation leading to disintegration and softening of the brain tissue. The pulmonary symptoms may have been secondary; or he may have had a congestion, preliminary to an acute pneumonia, acting as a prominent feature in the fatal result. Rapid respiration was certainly an early symptom.

The case is to me exceedingly instructive, because the indications for operation were clear, and because death occurred notwithstanding what seemed to be perfect aseptic conditions of the wound, during its entire course. It is a good illustration of the fact that modern surgery has not rendered serious operations entirely devoid of dangers. The diminution of the death-rate in operations has been great in recent years, but certainty of recovery is by no means as absolute as some reporters of operations would have us believe.

The next case is reported because of the youth of the patient.

Case IV. *Trephining for depressed fracture of the skull in an infant seven months of age; recovery.*—A mother, while carrying her seven months' old child along a railroad track fainted or had an epileptic seizure, and fell, dropping the child. When she regained consciousness the baby was whining and fretting a little, but did not seem badly hurt. After the mother reached home and removed the child's wraps, she discovered a large indentation of the skull on the right side of the head, which she supposed was due to the child's head having struck against a railroad tie, or upon the iron track. The baby did not have any symptoms of brain implication.

When seen by me on the next morning, the infant was perfectly comfortable, had slept well all night, played as usual, and had a good appetite. The mother believed the depression to be less marked than when the accident occurred. Examination revealed an irregular depression in the parietal and occipital region on the left side of the head. The lower extremity of the vertical diameter of this depression was about two centimeters above and five centimeters back of the top of the ear. The depression extended upward six centimeters. The horizontal diameter—that is, that parallel to the sagittal suture—began at a point near the anterior portion of the posterior half of the parietal bone, and extended backward six centimeters, very nearly bisecting the vertical diameter. The depression at its deepest portion was fully a centimeter below the surface of the skull.

At this time the patient's temperature was normal; pulse, 120. During the night two grains of sodium bromide were given because of slight restlessness. The bowels were opened by a soap suppository.

On the second day after the accident I found the child feeling well and the depression less marked than on the previous day, when I made the first examination. I felt unwilling, however, to let the injury go without surgical treatment, and therefore determined to make at least an exploratory incision, because the injury had been so severe as to make a very deep depression. The possibility of secondary symptoms, such as epilepsy or impaired intellect, seemed to me to indicate this slight operative interference.

An Esmarch's bandage was carried around the head before the incision was made, to prevent bleeding. A horseshoe flap was then dissected up at the point of injury. The bone was markedly depressed, showing a condition similar to green-stick fracture. I thought I could cut through the cranium with a strong knife, but found it necessary to use a trephine. A small trephine opening was made through very thin bone at the anterior edge of the depression, and the portion pushed down upon the brain easily elevated with the end of a grooved director. A few bleeding arteries were twisted, and the edge of the scalp wound

drawn together by catgut sutures. Boric acid powder and dry sublimate dressing was applied.

The patient re-acted from ether promptly and went quietly to sleep. Two-grain doses of sodium bromide were given at intervals until ten grains had been taken. The patient was restless through the night, but a few drops of paregoric quieted him. His bowels were kept open by injections of oil.

The temperature the day after the operation reached 101.8°, but soon all symptoms of fever disappeared, and on the seventh day the dressings were removed. The wound was found to have healed by first intention without suppuration.

At the end of the sixteenth day the patient was sent to his home in New Jersey entirely recovered.

In this case the accentuated character of the depression was the factor which led me to adopt operative procedures, although I know the tendency for depression of the skull in a healthy infant to correct itself spontaneously.

About eighteen months ago I saw a child who had received during birth a very marked indentation of the skull because the head had become locked on the promontory of the sacrum during delivery. The depression was situated on the left side of the head, and included portions of the frontal and parietal bones near the anterior fontanelle. It was about two and a half inches long and quite deep. The case was one of difficult labor, requiring forceps at the hands of Dr. Anna M. Fullerton, and the child, when born, was in the first degree of asphyxia, requiring the warm bath and artificial respiration. The child had frequent convulsions, beginning twenty-four hours after birth, evidently due to implication of the brain; yet I declined to operate, because I thought that the indentation was probably not associated with actual fracture of the soft bone. The convulsions ceased within twenty-four hours, and although the patient was under observation for several weeks, I never could convince myself that operative procedures were justifiable. The depression gradually lessened, and when the child was last examined by me seemed unimportant. The medicinal treatment of the child consisted of sodium bromide and potassium iodide. I have sometimes felt in regard to this case that the subsequent history might, perhaps, show that it would have been better to have interfered. I have not been able thus far to succeed in tracing the subsequent history of the little patient.

CASE V. *Specimen of cerebral tumor which could have been readily removed by surgical means.*—The brain herewith presented shows

a tumor occupying the parietal region, and was obtained from a subject in the dissecting-room of the Woman's Medical College of Pennsylvania. The history of the case is, therefore, exceedingly indefinite, though through the courtesy of Dr. George S. Robinson I have been able to obtain the following notes:

The patient was a woman, aged thirty-five years, of intemperate habits, who had, so far as known, no injury of the head and was not discovered to be syphilitic. She was an inmate of a public institution and was sent to its infirmary about a week before her death, complaining of a pain in her head, which seemed to be somewhat relieved by pills of an anti-neuralgic character. The headaches continued, however, notwithstanding medication, and for about two days vomiting occurred. The patient then became comatose and paralysis of the right arm and leg supervened. The pupils were somewhat dilated and did not respond to light. Respiration was slow and the face flushed. No convulsions occurred, but there were slight twitching of the facial muscles. The patient was not noticed to be blind or deaf. Death took place on the sixth day after admission to the infirmary.

An examination of the specimen shows a flat, circular tumor in the right parietal region lying between the dura mater and the cerebral hemisphere. The convolutions are pushed downward by the growth, but are not infiltrated in the least degree. The dura has not been preserved, but it is quite evident that the growth was attached to the inner surface of the dura, since its upper surface is torn and it has no attachments to the convolutions, but can be lifted out of its bed without disturbing their integrity. The tumor is almost circular when inspected from above, being six centimeters in the antero-posterior diameter, and 6.5 centimeters in the transverse diameter. It is flat from above downward, varying from two to three centimeters in thickness. It occupies the right parietal region upon the superior aspect of the cerebrum. Its anterior margin lies in a line with the calloso-marginal fissure, and pushes forward the ascending parietal, or posterior central, convolution. The tumor extends backward to the parieto-occipital fissure, crowding downward and backward the first occipital convolution. It extends outward and downward to the posterior end of the parallel fissure, or the first temporo-sphenoidal fissure, pressing upon the angular gyrus. The first and second parietal convolutions are flattened and lie underneath the tumor in the concavity made by its growth producing pressure downward. On the inner aspect of the hemisphere the tumor presses the convolutions downward, being nearly two centimeters thick where it lay in contact with the falx. The anterior edge of the tumor is about one centimeter farther forward than the posterior edge of the corpus cal-

losum. The gyrus fornicatus and the precuneus are pressed downward, but the cuneus does not appear to be pressed upon or displaced.

No surgeon can look upon this specimen without a feeling of regret that he could not have had an opportunity to attempt its removal. Its location immediately under the dura, its freedom from attachment to the cerebral convolutions, and its moderate size, would have made its removal easy. Its location behind the motor area is probably the reason that the patient's symptoms were not marked until just before the fatal termination of the disease. Her

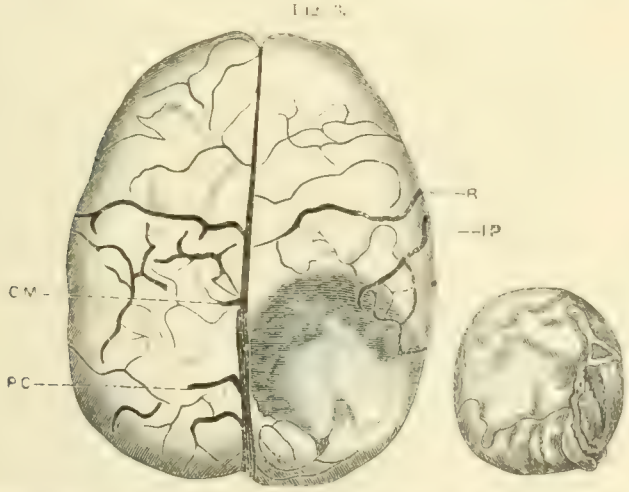


Diagram showing relations of brain tumor. R, fissure of Rolando; I P, inter-parietal fissure; P O, parieto-occipital fissure; C M, callosi-marginal fissure. The tumor has been lifted out of its bed.

habits of life and surroundings were such that she would not be likely to call a physician's close attention to the early manifestations of cerebral disorder, if, indeed, these were apparent to the patient herself. A large opening made with trephine, gouge or saw, followed by a similar incision of the dura, would have enabled the operator to lift the tumor from its bed without hemorrhage or disturbance of the cerebral convolutions. The growth is probably a fibroma.

The occurrence of right-sided paralysis seems rather curious, but Dr. Robinson states that he is sure of the correctness of this note, for he remembers that she used her left hand during her final illness. There is no evidence of a second tumor on the left side.

Possibly the growth may have so pressed against the falx as to have impeded the current in the superior longitudinal sinus, and thus have given rise to pressure on the left cortical centers near the upper end of the fissure of Rolando. Unfortunately, I did not see the specimen until after the dura and falx had been removed.

CASE VI. *Probable basal cerebral tumor, in which operation was deemed inadvisable.*—In September, 1889, a man, aged thirty-four, was referred to me by Dr. H. C. Bloom, who had reached the conclusion that his patient was probably suffering with brain tumor. The history was somewhat difficult to obtain from the patient, who had evidently some impairment of mental faculties. In childhood he had had otorrhea in each side, and thought that his present ailments, of two or three years' duration, had succeeded a renewed discharge from the left ear. About a year before I saw him he had fallen insensible; but for a year and a half previously he had had attacks of severe pain in the head, to the left of the median line. Some failure of vision had been observed for eighteen months; occasionally he walks unsteadily, but there is no apparent loss of power in arms or legs. His family thought his mental traits had shown change for several years. He is now becoming fat, sleeps a good deal, and is somewhat "weak-minded" in his conversation and facial expression. There was no direct history of syphilis. Optic atrophy was found in both eyes, being more marked in the left, with which he could only see enough to count figures. The vision of the left eye was $\frac{4}{LX}$. Examination showed him to have lateral homonymous hemianopsia and Wernicke's pupillary re-action. The fields of vision indicated a left-sided lesion. No deviation of the eyes was determined, but he thinks he has at times had double vision. Both tympanic membranes were perforated. He had had no epileptic seizures, but, as above stated, had once fallen unconscious. The urine had a specific gravity of 1010 and contained neither albumin nor sugar. The grasp of the right hand was stronger than the left, accountable, perhaps, to his profession—that of a dentist. Thermometric examination for several days showed him to be free from fever.

No anesthesia nor paresis could be determined Dr. B. Alexander Randall's examination resulted in finding in the left ear an old cicatricial condition, with a mere trace of discharge. The original trouble had probably been present in childhood, and was now in abeyance, though occasional exacerbations had in all probability occurred The right ear was in a state of chronic suppuration of the attic and adjacent cavities, with some likelihood of the existence of diseased bone. No involvement of receptive or central auditory apparatus was discovered by the use of tuning forks. The patient's symptoms were thoroughly studied for me by Drs. Charles K. Mills, H. C. Wood, Edward Jackson, B. A. Randall, and A. W. MacCoy.

From Dr. William Osler, who had seen the man some months before, I learned that then he had had an intense optic neuritis, but at that time no hemianopsia. Dr. Osler suspected a slowly growing neoplasm; probably located in an interior location because of the early alteration in habits

Dr. Mills was inclined to think that the symptoms shown when the patient came under my care pointed to a lesion between the optic chiasm and the primary optic centers. This he considered might be a tumor or abscess of the inner part of the temporal lobe, encroaching on the optic tract back of the chiasm, or a similar lesion of the cerebellum advancing and invading the more anterior structures.

Dr. Wood believed the localizing symptoms pointed to a lesion encroaching upon the corpora quadrigemina or optic chiasm, which was most probably either a localized meningeal inflammation with much exudation, due to diseased bone at the base of the skull, or a tumor there situated. He thought it possible that an abscess might exist in the temporal or frontal lobe, but there was little evidence to indicate this being a probability.

Fig. 4.

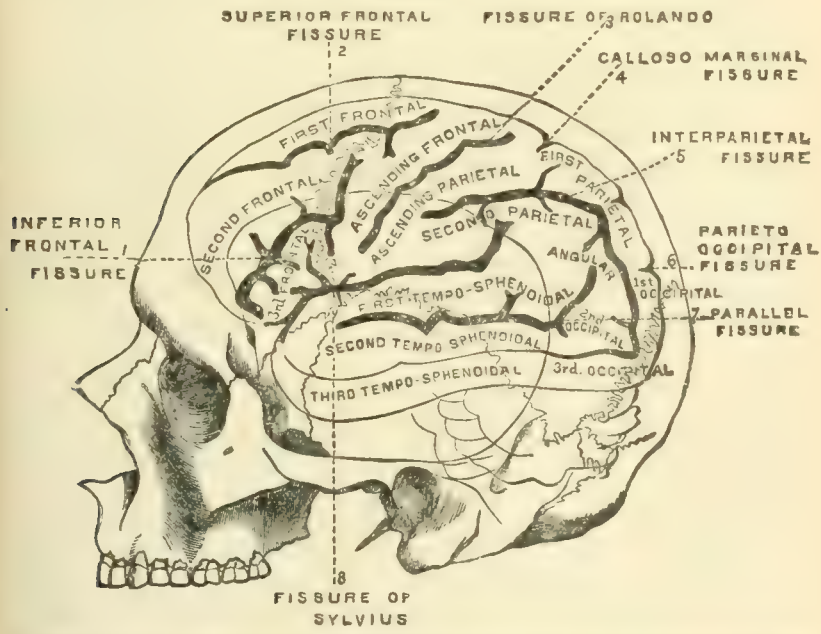


Diagram showing lateral view of the cerebral convolution, and fissures, to aid in making the description clear.

This case was one that offered a good many points of surgical interest; but, after determining that the lesion was probably basal and on the left side, I declined to operate, because there was no evidence of the left ear being a probable cause of intra-cranial suppuration. If the symptoms had pointed at a right-sided lesion, the condition of the right ear would have influenced me strongly toward operative measures, looking to the evacuation of a temporal abscess. The association of chronic aural suppuration with cerebral abscess is so well known that I think I should have strongly inclined to exploratory trephining.

I accordingly declined to operate, and sent the patient home. I heard from him frequently, but he gradually lost vision and mental power. I had arranged for, and obtained permission for, an autopsy; but when he died the past summer no word was sent me. Previously to death he had violent pain in the head, a prolonged chill, several successive convulsions and coma with high temperature. These symptoms occurred suddenly and terminated fatally in four days. Before that time he thought his eyesight, which had been almost totally lost, was improving. The time he survived after my examination, nearly two years, leads me to believe that our abstinence from operation was correct, since the lesion was more probably a tumor than an abscess. If a tumor, its removal was certainly impossible.

This case presents a picture different from the specimen before you, in which the tumor could have been lifted out so readily. I show a diagram of the cerebral convolutions, which may aid in following the description of these two cases of cerebral tumor.

I fully recognize that the record of these few cases has not been one of brilliant results. The death of some of the patients, and the short time between operation and this report in others, make the communication in some respects unsatisfactory. It has seemed to me, however, that there are elements of interest in the histories which will afford food for thought and open the way for discussion. It is for these reasons that I have been tempted to give these clinical histories, which are certainly not in any way remarkable.

A New Local Anesthetic.—Dr. C. Redard, clinical professor at the Geneva School of Dentistry, speaks highly of chloride of ethyl as a local anesthetic. It is a colorless, mobile liquid, having a peculiar and pleasant odor and a sweetish burning taste. Its sp. gr. is 0.9214. It is slightly soluble in water, but dissolves readily in alcohol. It is sent out for medicinal use in hermetically sealed glass tubes containing a little more than two drachms each. When required for use the point of the tube is snipped off, and the warmth of the operator's hand is sufficient to cause a very fine jet of the chloride to be projected on the part to be anethetized. Up to the present its use has been confined to dentistry and as an external application in neuralgic affections, but there is little doubt that in a short time its value will be tested in general surgery. Its action is similar to that of methyl chloride.—*Scientific American*, *Oct.* 24, 1891.

The Topsy of an "Uncle Tom's Cabin" troupe died recently and bequeathed her body to the doctors. Autopsy! *Texas Siftings.*

Society Proceedings.

From The American Journal of Obstetrics.

TRANSACTIONS OF THE FOURTH ANNUAL MEETING OF THE AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS.

HELD IN NEW YORK CITY, SEPTEMBER 17, 18, AND 19, 1891, AT THE ACADEMY OF MEDICINE.

(*Abstract.*)

(Continued from page 318.)

SECOND DAY—MORNING SESSION.

THE President, DR. A. H. WRIGHT, of Toronto, in the chair.

Dr. M. B. WARD, of Topeka, Kan., read a paper on

REMOVAL OF THE UTERINE APPENDAGES, WITH RESULTS.

He preceded the report of his cases by saying that operation for removal of uterine appendages is truly missionary work in Kansas. He performed the second operation of this character done in the State, February, 1890.

He then made a brief report of fifteen cases, in which he gave a history of the patient before the operation, the character of the operation, and the results at the time of writing the paper.

Three deaths were recorded, his first, third, and eleventh cases terminating fatally. Only one of the three was caused by the operation, and in that case the previous condition was deplorable. The reports of the cases were interesting and the results gratifying. Some of the conditions were extremely grave before the operation, and yet recovery in most of the cases was satisfactory.

DISCUSSION.

Dr. JOSEPH PRICE, of Philadelphia: We all know how satisfactory the results have been of late with this class of cases in dispensary and in public practice. We also know how distressing the results have been among the more wealthy, where harm follows from the delay due to treatment by rest and every other known method before resorting to radical measures.

Our mortality among the rich varies between six and ten per

cent. higher than among the poor, and there is no excuse for such a difference. A pus tube, an abscess in the pelvis, a pus accumulation in the axilla, under the deep tissue anywhere, should be removed. The treatment is precisely the same here. Good surgeons throughout the world will trephine for an accumulation of pus not larger than a hazelnut. Surely, if it holds good in brain surgery, it should hold good in pelvic accumulations. Again, just this state of affairs is common in all branches of abdominal surgery. It is so with gall stones and other hepatic accumulations. It is so notwithstanding we have had many years of special pleading, many voices crying in the wilderness—such men as Bantock, Keith, Tait, Thornton, and others pleading specially for early ovariotomy. We find large numbers of neglected cystomata, and the mortality remains higher than it should in that class of cases. He said that gonorrhea is unquestionably responsible for a majority of these cases. Gonorrhea is no longer treated by intelligent physicians. Every drug store in the land is a clap shop, probably as well in Boston as Philadelphia. It is a neglected disease. The sequelæ, in the male as well as in the female, are very much more marked than they were several years ago when the disease was treated by the educated physician.

Dr. E. W. Cushing, of Boston, said he appreciated and believed every word that Dr. Price had uttered. The bad cases that he had seen were the ones that had been neglected ; early operations had done well. Allowance must be made for the position of a man with his elders against him. It is dangerous for one to get too far ahead of the sentiment of the community. The weight of the teaching and the intent of every operator, as far as he can carry his people along with him, should be to operate early.

Dr. Mordecai Price, of Philadelphia, thought many of the delays were attributable to the cowardice of the surgeon. We all should know that when we approach a question where a life is involved, we should boldly consider every side, even though, if we operate and the life is lost, the community says that it was the operation. If we refuse to operate and death comes, we feel and know that it was but a consequence of our own cowardice. It is our business to go to these cases, and when we discover that pus exists, to remove it, and the sooner the better.

Dr. C. A. L. Reed, of Cincinnati, extended his congratulations

to Dr. Ward for his good paper, which is certainly to be recognized as pioneer work in the great State of which he is a citizen. He was impressed with the idea that gonorrhea in woman is a very serious affair. It progressively invades the mucous tract, climbing the vaginal wall, climbing the endometrium, invading the sanctum sanctorum of the female anatomy, and producing its most serious ravages upon the uterine appendages.

Dr. Ward, closing the discussion, thanked the Fellows for their kind compliments. In the West it is extremely difficult to get consent to perform these operations except as a last resort.

Dr. Joseph Price, of Philadelphia, read a paper upon

A CONSIDERATION OF EMMET'S LAST OPERATION FOR SO-CALLED LACERATION OF THE PERINEUM, OR PROLAPSE OF THE POSTERIOR WALL OF THE VAGINA FROM LOSS OF FASCIAL SUPPORT, OR MUSCULAR RELAXATION, OR TEAR.

At the meeting of the American Gynecological Society in 1883, when Dr. T. A. Emmet presented his paper on the Etiology of Perineal Laceration, with a New Method of Operation for its Repair, it was evident, in the words of an eminent gynecologist, that the members of the Society were very much at a loss to comprehend the steps of the operation as described by its illustrious originator. It is still not understood generally in Philadelphia, where at the present time we rarely hear of any one's performing the true Emmet operation unless it has been improved by some supposed modification. These modifications are for the most part meretricious. The Emmet operation seems to fulfil every indication for the restoration of the damaged perineum, far better than any other operation before or since devised, not excepting the so-called flap-splitting or Tait's operation, over which so much furore has lately been raised. The value of the operation has not been recognized, because the published reports of it have been so meagre and so little descriptive, excepting some explanations and modifications, that the very idea of the operation has not been grasped, except by those who, like the writer, have been fortunate enough to have Emmet personally demonstrate the operation and its advantages. Unfortunately, his original pamphlet was rather confusing than instructive and explanatory to those not already comprehending the operation. A drawing was necessary for the exact understanding of the successive steps of the operation. In several cases in

which Emmet's operation was performed, the writer had the assistance of Dr. J. Madison Taylor, who has sketched the appearance of the various stages. The theory of the mechanism of laceration is original with Emmet. He believes that the damage that leads to the severe consequences of loss of support to the pelvic diaphragm is principally in the deep layers of the pelvic fasciæ, a separation of the fibers of those fasciæ from the outlet of the vagina. The soft parts of the vagina are crowded up in advance as the fetal head passes. When the head of the child is forced down upon the so-called perineal body, the perineal tissues are stretched transversely before the head appears at all at the vaginal outlet. The so-called perineal body is attached principally at the two rami of the ischia through the strong and almost inelastic ischio-perineal fascia. When the head, following the sacral curves, crowds down the vaginal tissues before it, it meets its almost entire resistance from a lack of extensibility in these ligaments. If the force is severe enough they will separate, not by a tear from the fourchette downward, but by a separation of those fibers within the mucous membrane from their insertion without and below the vaginal orifice. It is the pelvic fascia that supports the vagina, this fascia often separated from its attachment to the vagina, or laterally from one or both rami at the passage of the head during parturition. The tear at the orifice of the vagina is of infinitely less importance than is the rupture of the ischio-perineal fascia. These fasciæ preserve the proper resilience of the floor of the pelvis. This removed, the anterior and posterior walls of the vagina have lost their support, and they must prolapse through the now weakened vaginal ring. It is well known that rectocele occurs constantly in patients in whom the fourchette has not been torn. A vagino-perineal laceration may pass around the sphincter ani. It is easily shown that the perineum is a thin diaphragm, not a body of firm fascia, muscle, or connective tissue. The rupture, which may or may not have been submucous, is not in the median line, but has been more severe on one side than on the other. In Emmet's expressive illustration, the bag has lost its puckering string. The prolapse is evidently due to a want of resisting power on the pelvic floor. Other operations have been previously devised to meet the same indications, such as those of Simon, Hegar, Hildebrandt, Freund Bantock, Baker, Brown and Emmet's trefoil operation. Some of these restored the perineum so that it was even longer than before, but failed in its real inten-

tion, since little by little the rectocele again prolapsed through the narrowed outlet to its original condition. A great advance was made when the denudation was extended so as to include a portion of the rectocele and so restore by cicatricial healing the perineal body. The results were frequently anything but happy. The old operations aimed to replace the perineal body by a new structure built from the adjacent parts; but when a perineum is lacerated it is not destroyed. If we can bring together the ends of the ruptured ischio-perineal ligaments, we will absolutely restore the supporting power of the perineum. Emmet's last operation aims at removing the superfluous vaginal mucous membrane at the vulvo-vaginal orifice, continuing at the same time the denudation along the line of the original rupture. As this line extends usually along the two sulci, the denudation assumes rudely the form of a crescent, whose convexity is the boundary of skin and mucous membrane of the vulva, while the concavity is marked by the summit of the projecting rectocele, and the cusps extend up the lateral deep sulci and posterior wall of the vagina. Finally he introduces sutures entirely within the vagina, beginning at the apex of a cusps and closing by bringing the two denuded edges of the cusp or sulcus, together. After the insertion of the crown stitch, one or more superficial stitches are sometimes necessary, according as there has been greater or less laceration. The essential landmarks of the operation—to-wit, the crest of the rectocele or its most projecting part, and the lateral mucous membrane at the highest point to which it is intended to carry the denudation—are not to be lost sight of or changed as the operation proceeds. After the sulci have been closed, when the crown stitch is introduced, the inside stitches entirely disappear. The after-treatment is simple—rest, catheterization if necessary. The bowels are to be kept easily open. The writer has yet to see the slightest inflammation—cellulitis or phlebitis—from the operation. The stitches are removed at the end of six or ten days, except those in the sulci. These latter are removed in the second week. This is best done by partially everting the vagina by a finger introduced into the rectum.

This operation most nearly approximates the natural perineum. The great degree of success attending the operation is alone sufficient to recommend it primarily in all lesions of the perineum.

DISCUSSION.

Dr. L. S. McMurtry, of Louisville, thought the importance of the subject increased by the great number of cases there are of

perineal rupture coming up daily in the practice of gynecologists, and the large amount of imperfect work that is done in this branch of surgery, and the incongruous advice that is given to patients upon this subject. The general surgeon does a good deal of this work, and it is very often the case that the skin only is united, and in all probability the skin is attached away up the vulvo-vaginal fissure, higher than it was in the natural condition; and in many instances the physician, finding that the fourchette is not torn, assures the woman that her symptoms are due to nervous exhaust ion and that there is no laceration of the perineum. It has been demonstrated this morning that you may sew together the skin without restoring the pelvic floor, and you may have the pelvic floor entirely destroyed without any rupture of the skin externally. Those are points which have been emphasized in the paper, which are not appreciated generally by the profession in regard to these injuries. The great difficulty in regard to the popularity of Emmet's improved operation for restoring the pelvic diaphragm is that it is difficult to clearly appreciate the operation without seeing it executed, and that it is very difficult to do the operation without giving it thorough consideration.

Dr. W. H. Wathen, of Louisville, thought Dr. Price had made an important subject unusually interesting, because of the practical manner in which he had presented it, and because of the vast experience he had had in doing successful work in this department of surgery, which makes all he says practical. In the main he fully agreed with him in his ideas and in his suggestions as to the proper means of operating. In operations where the tissues are torn down near the sphincter, with the anterior rectal wall presenting down in the vagina, he was practically in accord with the suggestions of Dr. Price, excepting that the procedure might be simplified by splitting the tissues between the rectum and the vagina latterly instead of denuding the mucous membrane. The splitting process can be accomplished by an experienced operator in less than half the time of the denuding process, and with not less than half the inconvenience from hemorrhage. The cardinal principle which should control us in this operation is to expose the ends of the torn muscles and the ends of the torn fascia, superficial, middle, and deep, and a failure to expose all these so that they may be brought together and held in position necessarily results in a corresponding failure in the result of the operation.

We ought to impress upon the general practitioner and the

general surgeon, as well as the specialist, the importance of attending to these cases wherever they are met, but, above all, we ought to impress upon the profession the necessity of attending to these cases when they occur. There is no operation of any magnitude in the whole range of gynecic surgery that has the element of simplicity so perfect and the universal results so attractive as in the operation for complete or incomplete laceration of the perineum, if done immediately after the accident has occurred.

Dr. J. F. W. Ross, of Toronto, believed that the denudation of the tissues outside is superfluous, but is necessary in the vagina, and that we can combine the operation of denuding in the vagina with flap-splitting in the perineum, exactly as Dr. Wathen had said.

Dr. Mordecai Price, of Philadelphia, spoke strongly in favor of the Emmet operation. He believed with Dr. Wathen that we have no business to know anything about secondary perineal work. It ought to be the business of the physician to have his materials with him, even if the case is a simple one, because accidents will occur in the best regulated households in that particular; and it ought to be his business to at once apply his sutures, because union is almost invariably by first intention in these primary operations, and there is no better way than to use the silkworm-gut sutures, passing them as Dr. Emmet recommends. The tear in nine cases out of ten is in the right or left sulcus.

Dr. H. T. Hanks, of New York, said he had been associated more or less intimately with Dr. Emmet in the Woman's Hospital for the last thirteen years, and had watched the development of the operation. He had been pleased to have the subject brought up for that very reason, because he has not only done good work in teaching us how to operate on a lacerated cervix, but has also given us some points in the operation on the perineum that we have not considered before, and which, when carried out to the letter as he has taught us, and as those of you who have seen him operate have been taught, give entirely satisfactory results. He believed the operation to be a successful one when well done, and done as Dr. Emmet had taught.

Dr. Joseph Price, of Philadelphia, closing the discussion, said: Some of us do the operation perhaps a little more than Dr. Emmet does—just a little more—but it all belongs to him. He taught us how to denude and everything that is good in plastic surgery.

Some of us go a little further than Dr. Emmet. Dr. Hanks has made a perfect illustration of Dr. Emmet's operation. Many of us differ in this particular. Dr. Emmet does not go as high in the sulci as some of his pupils with the denuding. Dr. Emmet makes a triangle with a tenaculum; we make it with a denudation, and go into the apex of that sulcus. We give the woman as much pelvic floor as possible. There are very serious doubts as to whether a flap-splitting operation ever restores a sphincter. I have yet to see the first one, and know at least half a dozen women in Philadelphia who have had the flap-splitting operation. They have incontinence of gas and feces when they have a diarrhea. I have seen men do it and absolutely miss, in their denudation and everything else, the dimples of the retracted sphincter, or half-moon. There are very few men in this country that can map out the sphincter in a perineal tear through the sphincter. Dr. Emmet, if you will follow him, will place his fingers on the sphincter and make you trace a hard, iron-like sphincter all the way round. He again has taught us all we know about sphincter tears that is worth knowing. Emmet's inside perineal operation with the sulci sutures closed is an operation which completes the woman's comfort. He need not put in those inside sutures, as far as the perfection of the operation and the comfort of the patient are concerned. The operation is complete when he completes his sulci work.

The President then delivered his annual address on

THE GENERAL AND SPECIAL MEDICAL SOCIETIES OF AMERICA.[1]

Dr. W. W. Seymour, of Troy, read a paper on

A CASE OF CHOLECYSTOTOMY AND CHOLELITHOTRITY; DEATH FROM "LA GRIPPE" THE TWENTY-FIRST DAY.

The gall bladder was incised and fine stones removed from it, and one stone in the common duct crushed by forceps applied to the duct. The crushing was done because the wound was so deep that the difficulties in the way of an exact suture of the duct in case of excision of the stone were enormous. At the autopsy, when death resulted from an intercurrent attack of grippe, the abdominal wound, save at the drainage opening, was firmly united, the adhesion of the gall-bladder perfect, and there was not the slightest evidence of suppuration, inflammation, or ecchymoses in

1. Published in full in the November (1891) number, page 193.

or about any abdominal organ. The inferences drawn were: 1. That in large, fat, and flabby bellies crushing is safer than excision with its risk of imperfect suture. 2. That excision should only be a method of election where an exact suture is beyond question. 3. That if there is any suspicion of injury to the duct, drainage should be inserted to the suspected point, and, if needed, the abdominal cavity protected by gauze tampons. 4. That in case of stones projecting into or overlying the duodenum, the duodenum may be incised and the stone, if projecting, broken up, or the duodenal portion incised and the stone crushed or delivered intact, as Dr. Charles McBurney has recently successfully done with a stone as large as a pigeon's egg.

Dr. A. Vander Veer, of Albany, read a paper entitled

REPORT OF CASES OF CHOLECYSTOTOMY, WITH SPECIAL REFERENCE TO THE TREATMENT OF CALCULUS LODGING IN THE COMMON DUCT.

He said: In presenting this paper as a contribution to the surgery of the gall ducts, I shall refer somewhat to the surgery of the gall-bladder. Yet my chief desire is to get from you a discussion and your views regarding a line of treatment in cases where we find a contracted and perhaps almost obliterated gall-bladder, or where the common, cystic, or hepatic ducts are entirely closed by lodgment of a calculus, or stenosis from other causes. He then presented a group of three cases illustrating these points, in which he had operated twice successfully, and exhibited specimens removed in each. From his experience in these and other cases he offered the following:

This operation is not very difficult, and the results favorable beyond a doubt; but does not this method deter us in some cases from pushing ahead and relieving cases where practically no gall-bladder is to be found? Are we not too conservative at times where we have stenosis, severe adhesions, and apparently no gall-bladder present?

The intent of this paper is to deal only with those cases where there is an obstruction of the ductus communis choledochus, the cystic or hepatic ducts, from any cause whatever. Cholecystotomy, with suture of bladder walls to parietal wound, when the viscus is fairly well developed, is not a serious operation. Primary and secondary opening of the gall-bladder I mention here to em-

phasize the fact that I believe the latter is always to be condemned for the following reasons:

1. It is always necessary, before the closure of the abdominal wound, that the gall-bladder be opened and emptied, as it is often impossible to recognize conditions until then which will require manipulations not only within the gall-bladder, but also within the abdomen.

2. Prolonged obstruction in the intestinal portion of the common duct may lead to its dilatation, together with that of the gall-bladder, and the destruction of anatomical outlines. Biliary calculi lying in the common duct, in the hepatic or at the mouth of the cystic duct; stricture of the ducts from local ulceration (exceedingly rare), or occlusion of them from external causes, as cancer of the pylorus or the last portion of pancreatic duct, all require treatment for relief beyond either cholecystotomy or cholecystectomy.

I believe it is possible to freely loosen adhesions that have formed in the region of the gall-bladder, and in all cases of severe traumatisms we should not hesitate to make use of the tamponade of iodoform gauze and drainage, or employ the method so clearly recommended by one of our Fellows, Dr. Morris.

Dr. H. O. Marcy's paper on Relief for Biliary Obstruction defines the steps of the operation very closely, particularly in relation to suturing of the incision made in the gall duct.

The operative technique may be varied as follows, by—

1. Dislocation of the calculus *en masse*, either into the duodenum or into the gall-bladder.

2. Cholelithotrity, either by crushing through the walls of the duct with padded forceps or fingers, or from within the gall-bladder by means of the needle or fine probe, followed by removal by the way of the gall-bladder or intestinal canal.

3. Breaking of the calculus by the introduction of strong needles through the walls of the duct, and subsequent dislodgment of the fragments.

4. Cholecystenterostomy according to Von Winiwarter, or modifications of it as have been suggested to Gaston in his elaborate experiments upon dogs.

5. Incision of the gall duct and removal of the calculus, with subsequent suturing of the incision in the duct.

The application of these methods conflicts with some notions in surgery which to my mind are altogether fallacious. The first is,

that sutures can never be applied to the gall bladder and ducts with safety. The first cholecystotomy was followed by suture and recovery.

The second notion is that the healthy biliary secretion always causes peritonitis when free in the abdominal cavity. The experience of Schuppel, Bostroun, the cases of Paraisse, Sabatier, Thiersch, etc., demonstrate the falsity of this dogma.

We must put these fallacious ideas behind us, as we have many concerning the technique and management of abdominal section. I believe in a wholesome fear of the peritoneum and of throwing around our patients every possible safeguard. I should not like to complete an operation knowing that bile might flow over the intestines, but I believe that such wounds, by proper drainage and iodoform-gauze tamponade, can be made comparatively safe for the patient, much safer than the condition for which the operation was done.

Those cases which present the least difficulties are where the calculus can be removed *en masse* by pushing either into the gall bladder after cholecystotomy (preferable) or into the duodenum. The danger of tearing the duct across its diameter, as has already occurred, must be kept in mind, and will somewhat circumscribe the operation of fracture or incision and removal from the intestine.

The second procedure, together with the third, may be employed in suitable cases, but the choice will lie between them and the fifth procedure, that is, incision and removal.

The fourth method of treatment, by establishing a new communication between the biliary ducts and the intestine, must always have a certain utility, especially where it is found that the seat of obstruction (the common duct) is bound down by adhesions and cannot be made accessible.

To one doing abdominal work I would advise a careful perusal of Dr. Gaston's paper in *The Atlanta Medical and Surgical Journal* in 1884, entitled Experimental Cholecystotomy.

In France the operation bearing the name of Von Winiwarter has recently received much attention, and flattering results are reported.

Under the fifth division—that is, incision and suture of the gall ducts—we have, I believe, in many cases a method which promises great success, where heretofore cases have been treated by establishment of biliary fistula, which only relieved for a short time. So far as

I have been able to learn, incision of the common duct has been seldom performed in this country. The technique of the operation is as follows: Usual vertical incision, from tip of cartilage of tenth rib, made of sufficient length to permit free examination. It may be necessary to complete the operation by making a transverse incision through the right rectus abdominalis. Incision over stone, in line of duct, is made. Fluid behind duct should be withdrawn by aspirator, or sponges placed to protect surrounding parts. First row of sutures continuous, introduced just within serous coat of duct, brought just within the mucous coat, but not involving it; second series, Lembert, bringing the serous coat into accurate apposition. Surround drainage-tube on all sides with iodoform gauze tamponade, the ends being left in abdominal wound, closing latter with silkworm-gut. One or two silkworm-gut sutures may be introduced and tied in loop, so that after removal of tamponade they may be tied and abdominal wound more completely closed.

DISCUSSION OF THE TWO PRECEDING PAPERS.

Dr. R. T. Morris, of New York: There is one method of procedure, in cases of gall stones, so simple that I wonder that anybody has failed to think of it. Gall stones can be dissolved very easily by chloroform, ether, and some of the marsh-gas series. We do not need any forceps. We can remove the greatest element of danger by dissolving them right in place. The operation consists in suturing the gall bladder to the abdominal wall, then waiting for forty-eight hours until adhesion has taken place. The cases of greatest danger after operation are those followed by leakage of bile or mucus or the fermenting contents from the gall bladder into the abdominal cavity. Therefore, the ideal procedure consists in first suturing the gall bladder to the abdominal wall, waiting until adhesion takes place, opening the gall bladder, and with a syringe injecting down upon the gall stones, at any time you please, a week or a day or a month after, a chemical that will make a solution of the cholesterin quickly and safely without imposing the grave danger upon the patient of crushing, bruising, or injuring the common duct. I am making experiments in this line to find some non-irritating solution which will dissolve the gall stones easily.

Dr. L. S. Pilcher, of Brooklyn, recognized the fact, as all surgeons do, that the gall bladder has become a fit subject for surgical interference, and that, with the rapidly increasing experience

which is being gained in work upon that organ, we shall soon have well-established indications for not only examining the organ, but also for the different classes of operations which we shall be called upon to do, for the relief of the conditions which we find present in it. The ideal cholecystotomy, in which the organ is exposed, is opened, is evacuated, is closed and dropped back into the abdominal cavity, suggests itself as an operation extremely desirable to be done, if the conditions are such as to make it feasible to do it. The extirpation of the gall bladder has been done, and will at times be found necessary if we are to relieve the conditions which have made operation of any kind necessary. The difficulties which attend the operation are great, and it can only be rarely that a surgeon will feel justified in undertaking its accomplishment. The opening of the common duct and the removal therefrom of a gall stone have been described to us this afternoon. The successful performance of the operation has again and again been demonstrated to us. The possibilities of relief which are open by means of that should always be present in the mind of the surgeon. He then presented and discussed some specimens of gall stones.

Dr. M. B. Ward, of Topeka, stated that he had done the operation twice on a dog, removing the gall bladder entirely. His first operation was a failure, death occurring from general peritonitis on account of some defect in the operation. The next dog got well and very fat, and was subjected to three other operations on the intestines. He inquired whether the gentlemen found it easy to bring the gall bladder up and attach it to the parietes. He found it difficult unless the gall bladder was enlarged.

Dr. Seymour, closing the discussion on his part, said, with regard to the attachment of the gall bladder to the abdominal wound, the method pursued by Mr. Tait is very satisfactory, particularly in cases of contracted gall bladder. That is, not to attempt to bring the gall bladder up to the level of the skin, but to suture the gall bladder with an interrupted buried silk suture at an intervening height in those tissues, taking a sufficient number of interrupted sutures to give strong and firm coaptation of the structures. He considered the matter of dissolving gall stones within the gall bladder as still *sub judice*. In view of that, the operation of Tait—opening the gall bladder with establishment of a fistula—is the most rational operation. He considered it very possible that there would be a recurrence of the disease with the

persistence of the constitutional condition. He considered the silk suture preferable in this operation to any of the animal sutures.

Dr. VANDER VEER, closing the discussion on his part, said that in reference to attaching the gall bladder to the parietes, he would only add this, that before the gall bladder is attached to the incision, and before it is opened, we should make a very careful examination of the common duct and be very certain as to the condition of the pancreas.

Dr. W. H. WATHEN, of Louisville, read a paper on

ASEPSIS IN INTRAPERITONEAL SURGERY.

If the proper precautions as regards cleanliness in every detail before and during an operation are observed, we need no antiseptic germicides in intraperitoneal surgery. If solutions of sublimate, carbolic acid, etc., are brought in contact with healthy peritoneum, their action is harmful. I will not condemn the use of chemical solutions for the purpose of sterilizing the operator, assistants, nurses, or patient, or the room, instruments, sutures, dressings, sponges, etc., if used before the operation is begun ; but the chemical germicide should be removed from everything that is brought in contact with the peritoneum. Unless everything is made practically clean independent of the germicide, that will not make it aseptic. It is too often true that operators who are loudest in advocacy of germicide solutions are the least cleanly, and I have known a few of them to forget to wash their hands before beginning an operation or before examining a woman in labor.

There are relatively few men who know how to be surgically clean in every detail connected with intraperitoneal surgery, and if the time and labor that have been devoted to teaching the medical profession how to use antiseptic germicides had been directed to teaching the value of, and means of accomplishing, surgical cleanliness, septic peritonitis following laparatomy would be comparatively infrequent. Of course, the above does not apply to all men who use chemical antiseptics, for some of them are the most cleanly men I have seen operate, but I believe they would get as good or better results if they omitted the antiseptics. The peritoneum is usually infected by contact, and the danger of atmospheric infection is practically *nil*, as has been shown by the excellent results in laparatomies done in large and crowded amphitheatres.

He explained in detail the latest and most improved methods in asepsis. He advocated drainage with a small glass tube open at both ends, with fine holes on sides extending within two inches of the mouth. He opposed the practice of introducing the wick or gauze in the tube, and preferred to remove the blood and secretions by suction with a long-nozzle syringe or a syringe with a gum tube attached.

Dr. Henry O. Marcy, of Boston, read an essay entitled

FEMORAL AND VENTRAL HERNIA IN WOMEN.

The methods by which the author obtains a radical cure are original, and are followed by most exceptional results. He advocates the dissection of the sac to its very base, which is sutured across and removed. The internal ring is carefully closed by a line of deep, double, continuous tendon sutures. The canal is narrowed and closed in a similar manner, and the wound is sealed with iodoform-collodion, without drainage. The operation is conducted with the strictest antiseptic care; and since Dr. Marcy was the first to use and publish the advantages to be derived from buried animal sutures, and systematically to extend their applicability in the general field of surgery, we quote his emphatic directions: "There is but one rule, and it cannot be too rigidly enforced—the *aseptic* suture must be *aseptically* applied in *aseptic* structures, and the wound must be maintained *aseptic*. The failure of either of the above-mentioned factors not alone endangers the result, but may be followed by the most serious consequences. Modern surgery demands of the operator every safeguard to insure an aseptic wound, but he who uses buried animal sutures must take, if possible, even greater precautions, since infection carried into a wound thus firmly closed is, for obvious reasons, attended with much greater danger than in a wound united by interrupted sutures which, at the end of a few days, are to be removed, and where drainage is relied upon to permit the escape of infective or foreign material. It is in part on account of defective technique, the use of drainage, and the too often septic wound that failure to effect a cure after hernial operations so generally occurs.

"I began to use the buried animal suture in operating for the cure of hernia in 1871, and since that time have for the most part used it in the closure of all operative wounds; and in all my operations for the cure of femoral hernia, where the integrity of the

intestine has not been involved, I have never observed a subsequent symptom indicating danger, and, so far as I have been able to learn, there has not been a single recurrence. There is little pain, and even edema of the tissues does not ensue. After a few days in bed the patient is allowed to sit up. In some instances I have permitted the use of the chair the second day, without any apparent harm. I never advise the subsequent application of a truss. . . .

"If it can be demonstrated that femoral hernia is curable, then the advisability of the operation should be taken into consideration; and if it can be proved that the cure remains permanent, it adds much to the argument in favor of operative measures; but where it is demonstrated that, under proper precautions, based upon an accurate anatomical knowledge of the structures involved, the operation is not severe, does not cause long detention from active duties, does away with the punishment inflicted by the life-long wearing of a truss, and is almost without danger, there remains no reason why all the sufferers from femoral hernia should not profit by surgical measures and demand to be restored to the ranks of active service."

Dr. Marcy makes an equally strong plea in behalf of surgical intervention for the cure of sufferers from umbilical and ventral hernia. In umbilical hernia he dissects the peritoneal sac quite within the margin of the ring, sutures it across at its base, and resects it. The subsequent steps of the operation are conducted under irrigation. There are conditions when it is wise to resect the ring and close as in an ordinary laparatomy; but the method which Dr. Marcy more generally recommends, is one quite peculiar to himself. The structures composing the ring are divided laterally upon the plane of the abdominal wall, about one-half of an inch in all directions. This admits the coaptation of the sundered parts, and, by lines of strong, continuous tendon sutures, the separated edges are coaptated in a way greatly to broaden the united parts. This widens the line of union to an inch or more, instead of bringing together the narrow edges of the tendinous ring; and, besides affording this great depth to the united portions, it brings together refreshened surfaces in a high state of vitalization, likely to be followed by firm union. It also admits the joining of the tissues in three distinct layers of strong sutures. As in the other forms of hernia, the skin itself is closed by a line of running or lacing sutures, taken from side to side through the deeper portions of the skin only, which admits of its coaptation by sutures

entirely hidden from view. Such a wound requires no drainage, and it is permanently sealed with collodion. The weight of years of experience in active surgical practice enforces the value of Dr. Marcy's contributions upon a subject of the highest surgical importance, since the radical cure of hernia is considered by many as yet *sub judice*.

DISCUSSION.

Dr. J. H. Carstens, of Detroit, said everything stated in the paper gave him pleasure except the employment of ether. He hoped some time the hub would learn from the tire out West that chloroform was the best anesthetic. In operating he made the usual incision, and returned the gut if all was right. He then took silk, with the needle which he used for operating on the lacerated cervix, and encircled the hernial opening completely. He tied that so as to close it up perfectly. He did not like to trust the buried animal suture. He dissected out the sac in the usual manner and cut it off short, then took catgut and with that sewed the wound carefully in the usual manner until the wound was entirely closed except the skin, which he closed with two or three silkworm-gut sutures. He used no drainage-tube. He wished to strongly emphasize what Dr. Marcy had insisted upon, viz., that the time for the drainage-tube in the operation for hernia ought to cease.

Dr. H. O. Marcy then exhibited to the Association some specimens of kangaroo tendon, and explained the method of preparing the various animal sutures.

Dr. W. J. Asdale, of Pittsburgh, said, with reference to the drainage-tube, that he used it when in doubt what to do. He regarded the tube with many small perforations as a dangerous one. He followed the practice, where he used the drainage-tube, of turning it at short intervals, every few hours—at any rate, at every visit.

Dr. R. B. Hall, of Cincinnati, said that he had practised drainage in every case of abdominal section since October, 1887. He had never had occasion to regret placing the drainage-tube. Some cases in which he placed the tube, feeling at the time that it was not necessary, would, undoubtedly, have died had the tube not been placed.

Dr. E. E. Montgomery, of Philadelphia, had for a long time been averse to introducing silk either into the wound or covering it up in the abdominal cavity. In re-operation upon a case a year

or more after the first operation, he had found the silk still remained, and in some cases it was a source of irritation. He was strongly inclined to the use of the animal ligature. He had not had the opportunity to use kangaroo tendon, but had resorted to carefully prepared catgut. He considered the care of the instruments as a very important part of the technique of abdominal surgery, particularly the needles. He advocated cleansing the needle with a soapy towel, then cleaning it with benzine, and finally placing it in absolute alcohol. When the catgut and needles were ready for use, they were placed in a tray and covered with alcohol. If the catgut is placed in water, it softens and swells, and is somewhat difficult to tie; but from the alcohol it is hard, and when it is introduced, it swells and fills up the track made by the needle. Dr. Wathen made a good point in regard to drainage. It is usually considered that drainage should be from the lowest portion of the abdomen; but if we look at the abdomen when it has been cleansed and the intestines have settled down, we will find that the liquid gravitates to the upper surface. He had no doubt but that many cases of intestinal adhesion were due to the fact that there was present a fluid which, to a slight degree, became infected sufficient to give rise to a slight superficial peritonitis and gluing together of the surface. In these cases drainage by gauze or by wick is oftentimes very efficient.

[*Concluded next month.*]

THE MEDICAL SOCIETY OF THE COUNTY OF ERIE.

Reported by ELI H. LONG, M.D., Secretary.

The annual meeting of the Medical Society of the County of Erie, held January 12, 1892, was called to order at 10 o'clock A. M. by the President, Dr. E. C. W. O'Brien.

The minutes of the last regular meeting and two special meetings were read, and, upon motion of Dr. J. J. Walsh, adopted.

Dr. M. D. Mann moved that the record of censure passed upon Dr. Harrington be stricken from the minutes, and that all matter referring thereto, together with new evidence which he would present, be referred back to the Board of Censors to report at the next meeting of the society. The motion was seconded by Dr. Hopkins.

Dr. J. D. Bonnar moved to amend that the case be reopened before the society. Seconded by Dr. E. L. Bissell.

A discussion followed, participated in by Drs. Storck, Hayd, Potter, Harrington, Hopkins, Coakley, Bartlett, Cronyn, Abbott, and

others, in course of which Dr. Harrington expressed deep regret for his uncomplimentary reference to the members of the society which had appeared in the public press. In consideration of this and other statements made in explanation by Dr. Harrington, it was moved by Dr. Wyckoff as a substitute motion that these be accepted as a sufficient apology, and that the whole matter be stricken from the records of the society. Carried.

The Secretary moved that the chair appoint a committee of five to nominate officers for the ensuing year, to report at the afternoon session. This was amended upon motion of Dr. Storck to the effect that when the proper order of business is reached, the society shall proceed to nominate and elect officers in open session. Carried. The Committee on Membership recommended the following-named physicians for election to membership: W. H. Baker, C. A. Schladermundt, Harriet E. Sheldon, Fred H. Powell, Chas. S. Meahl, E. H. Tweedy, Chas. H. Woodward, Chas. P. Clark, Lillian C. Randall, A. B. Kinsley, Lewis G. Smith, Irving W. Potter, Arthur B. Allen, Chas. J. Reynolds, John R. Gray, Francis L. Watkins, Frederick Preiss, and F. E. Hill.

Upon motion they were duly elected, and those present were introduced to the society.

Dr. Hubbell moved that after "Communications from Abroad," in the regular order of business, the programme of scientific papers be taken up. Carried.

The Committee on Membership reported the following applications for membership, to be acted upon at the next regular meeting: W. F. Beutler, J. M. Hewitt, A. J. Colton, M. V. Ball, J. J. Drake, L. A. Denton, Mary I. Denton, H. U. Williams, J. T. Harris, E. J. Gilray, B. C. Johnson, A. E. Collins, and A. G. Bennett.

The Treasurer presented his report, showing a balance in the treasury of $292.53, which, upon motion, was referred to an auditing committee, consisting of Drs. Cott, Hayd and Edward Clark. Upon their favorable report the Treasurer's accounts were passed.

The Board of Censors, through its chairman, Dr. E. Storck, presented the following report:

To the Medical Society of the County of Erie:

The Board of Censors at its last meeting directed its chairman to report as follows:

At the semi-annual meeting, in June, 1891, the society was informed that the board had notified Dr. Francisco Palmiere that he was practising in this city in violation of the State law, as he

had no diploma registered in our County Clerk's office. It was also claimed by some of his countrymen, who appeared before your board, that he was not the rightful owner of the diploma that he possessed. The diploma was submitted to Dr. J. Cronyn, the President of the medical faculty of Niagara University, who declined to endorse it, for the reason that he was not convinced of the identity of the person. The applicant having refused to submit to a personal examination, the diploma was then submitted to the State Board of Medical Examiners for endorsement, and license applied for through his legal adviser. The State Board was informed of the foregoing statement of facts, and of the action taken thereon by your board.

Prof. Thomas, the Chief Examiner, has lately sent to your board a letter that he had received from the Italian Consul-General in New York, which reads as follows: "The foreign office in Rome has directed me to assure you that the diploma submitted to me has been inspected by the University of Naples; the same has been recognized as *genuine*." The Chief Examiner adds: "The letter explains itself. We now see no reason why the diploma of Dr. Palmiere should not be endorsed. Dr. Palmiere has complied with our requirements, the only question in his case being the genuineness of his diploma."

Though this decision settles the question satisfactorily to Dr. Palmiere, your board begs leave to differ from it in one respect. We hold that the genuineness of the diploma should not be the only criterion, but the identity of the person should be established beyond a doubt. This can only be done by a personal examination.

The case of Ferdinand Simon has finally been disposed of by the State Examiners. They rejected the documents he had submitted as being simply testimonials of service as hospital steward, therefore no license was granted. This case has become quite a *cause célèbre*. Medical journals east and west have taken notice of it. After a member of this society had been expelled for having been connected in business and practice with Simon, the board was informed that legal proceedings would be commenced against this society for its action, as Dr. Simon was in possession of a diploma of a legal medical college in Cincinnati, O. Your board, however, induced the District Attorney to bring the case again before Judge Seaver. At the trial the plea was brought up by the learned counsel for the defendant, who claimed that such a diploma was to be submitted to the State Board of Examiners. Further time was granted by the court. The diploma was examined by Dr. W. W. Potter, one of the State Examiners. It had been granted to Ferdinand Simon by the American Eclectic College, of Cincinnati, O., and is dated June 6, 1891, bearing the signatures of nine professors and the golden seal of the institution. It was obtained by Simon —so he informed your board—in one day. He passed a *pro forma* examination before one of the professors for which he had to pay

a round fee, and $25.00 in addition for the diploma. This diploma was naturally rejected by our State Examiners, and no license granted. The result of this case has proven two satisfactory points: First, that your board has been fully justified in the prosecution of Simon and his partner; second, it has demonstrated the great advantage of having a State Licensing Board that will not issue a license to practise in this State on the mere presentation of a sheep-skin of a so-called medical college that claims to have a legal existence. The days of such institutions are numbered.

Of the other cases your board had brought before the Grand Jury: Horace Dewey and Ellen Crossley after they had been indicted decamped for a more genial climate. The District Attorney does not seem to be very anxious to look them up, neither are we.

The clairvoyant doctress that was not indicted on account of that rheumatic grand juror from a "rural deestrict," is still quacking in violation of the law. Her case, however, is in the hands of the District Attorney, who will again bring it before the grand jury if sufficient evidence can be furnished.

Dr. C. Zolotwitzki, a Russian physician on Clinton street, has been practising for some time in this city. He has been notified by the board that he is violating the medical law, not having effected any registry. The diploma he holds of a Russian medical college seems to be genuine, but so far he has not submitted the same to the State examiners. Unless he complies with the law, the Censors will ask the District Attorney to prosecute him, and he has been served with notice to that effect.

This completes the business of the Board of Censors for the year 1891. The chairman hopes that this will also be the last report he will be called upon to make. Having performed the duties and labors of this office—which have often been onerous and disagreeable—cheerfully and conscientiously, he now asks the society to relieve him from the task in the future. Recent unpleasant occurrences have made it doubly a burden. The Censors, as the legal executive officers of the society in carrying out the medical laws and the by-laws of the society, in bringing offenders to justice and discipline, necessarily have made personal enemies; but that the chairman, discharging his duties without fear or favor, should call down upon himself the wrath and displeasure of some of the prominent members of the medical profession and be persecuted and condemned by them, seems rather strange. The board, since he has been a member and chairman thereof (twelve years), has endeavored to elevate the standard of the medical profession and of medical education. Some twenty years ago he submitted a bill to the Legislature "to regulate the practice of medicine and surgery in this State;" it was passed by both Houses, but some prominent and, I may add, orthodox physicians of Albany prevailed upon Gov. Hoffman to veto it. A few years later the bill passed the Assembly, but was smothered in the committee box in the Senate. In 1880

we finally got the registry law in force, that made it a misdemeanor to practise without having a diploma or license duly registered. The censors of both schools of medicine in this county first carried this law into effect. The itinerant quack was driven out of the city or arrested ; the local irregulars were compelled to comply with the law or desist from practising. The people, more than the profession, received protection from the enforcement of this law. It was your Board of Censors that first instituted legal proceedings, by applying to the Attorney-General of the State for a writ against the bogus medical colleges that granted diplomas without having a legal charter. We argued the case before Gov. Cleveland, who declared their charters null and void. This action involved considerable expense to our society, but the result was worth the money.

The first action taken to secure the passage of a law "to create a State Board of Medical Examiners," was by a resolution of your board that passed this Society eight years ago ; further action thereon was taken, to which Dr. W. W. Potter, of this city, referred in his address as President of the State Medical Society last year as follows : "Year by year the note of warning has been sounded on the subject of separating the teaching and licensing powers. More definite shape, however, was given to the matter some seven or more years ago, when the Committee on Legislation of the Medical Society of the County of Erie reported a plan for the complete separation of the 'unfortunate, unwise and debasing copartnership of the educating and licensing powers.' The bill drawn by this committee was submitted to and approved by the State Medical Society and introduced in the Legislature ; it became a law June 5, 1890, and is now in full operation."

This is a résumé of our work done in the past. If the writer has contributed a good share thereto, and helped to secure these great results, which will prove beneficial to the medical profession and the people of this State alike ; if his efforts in this direction have met your approval and that of the members of our profession in this city and county—he will be well contented.

In conclusion, the writer desires to state in justice to his colleagues who have been members of the Board of Censors, that the charges preferred against members of this society for violation of the by-laws have not emanated from any of them nor from the chairman, but when such charges are made by other members, and the censors are appealed to by the members of the society for protection, it becomes the duty of the board to take notice of it and report the result of the investigation to the society. If the board is not sustained in the discharge of its duties and in its action, if members are allowed to violate the by-laws without being disciplined, if the dignity of the profession is not upheld, what use is there in having by-laws and a Board of Censors ? What is the object and purpose of the Medical Society of Erie County ?

Respectfully submitted for the Board of Censors.

EDWARD STORCK, *Chairman.*

Dr. J. B. Coakley moved that the report of the Board of Censors be adopted, together with the following:

Resolved, That the thanks of this society are due and are hereby tendered to Dr. Edward Storck for the faithful performance of his duties as Chairman of the Board of Censors. Carried.

The society then proceeded to the election of officers, with Drs. Edward Clark and J. J. Walsh acting as tellers. The election resulted as follows: *President*, William Warren Potter; *Vice-President*, William H. Gail; *Secretary*, Eli H. Long; *Assistant Secretary*, Ira C. Brown; *Treasurer*, Edward Clark; *Librarian*, Charles A. Ring; *Censors*, Edward Storck, H. R. Hopkins, P. W. Van Peyma, J. J. Walsh, Henry Lapp; *Membership Committee*, A. A. Hubbell, John A. Pettit, W. C. Callanan; *Delegates to the Medical Society of the State of New York*, B. H. Grove, Edward Clark, E. C. W. O'Brien, Ernest Wende, H. E. Hayd. The Treasurer was authorized to appoint his assistant officer.

The society then adjourned to meet at 2.45 p.m.

AFTERNOON SESSION.

The society was called to order by the president at 3.15 p. m.

The president's address being in order, Dr. Coakley was called to the chair and Dr. O'Brien gave an address upon Progress in Medicine and Surgery, with special reference to work done in this country, this State and this County.

Under Miscellaneous Business, Dr. F. W. Abbott read an acknowledgment from Dr. Samo, which was ordered filed. Dr. Abbott moved that credit for dues be extended indefinitely to Dr. Samo. Carried.

The amendment to the by-laws offered by Dr. Storck at the last regular meeting was read, and in the absence of the mover was laid upon the table until the next regular meeting.

Upon a statement by the Secretary that our file of the Transactions of the Medical Society of the State of New York lack the volume for the year 1835, the officers were authorized to procure this volume if possible.

It was moved and carried that a committee of five be appointed to prepare a programme for the semi-annual meeting, three members to be appointed by the chair, the President and Secretary to be the other two. The chair appointed Drs. A. A. Hubbell, J. H. Pryor and H. E. Hayd.

By unanimous consent the President was authorized to appoint delegates to the Medical Association of Central New York.

The following resolution, moved by Dr. C.A. Ring and seconded by Dr. Putnam, was adopted :

Resolved, That our delegates to the Medical Society of the State of New York be instructed to request that Society by its Committee on Legislation to frame a bill for presentation to the Legislature, restricting the practice of hypnotism to legally qualified medical practitioners, and prohibiting public exhibitions of hypnotism.

A communication from the Secretary of the State Medical Society announcing its next meeting, etc., was received and filed.

The Secretary read a letter from Dr. Bernard Cohen, in which he expressed regret for the causes which led to his expulsion from membership, and asked to be reinstated. Upon motion of Dr. Hartwig, Dr. Cohen was reinstated by a unanimous vote.

The Secretary read letters of resignation of membership from Drs. J. Falk and G. H. McMichael.

Dr. B. H. Long moved that these resignations be laid on the table until an opinion was had of the Board of Censors as to whether a member's resignation can be accepted by the society.

Dr. Hubbell moved as a substitute that these resignations be accepted. Lost.

The motion to table was then carried. President O'Brien, Drs. Park, Putnam, and Hubbell found it necessary to be excused at this time.

The programme of scientific papers was then taken up and the following read: By Dr. M. D. Mann,—Laparatomy, Six Times in the Same Patient. By Dr. A. L. Benedict,—The Practical Use of the Metric System. This paper included a report from the committee appointed at the last meeting to report upon this subject at this time. The facts were presented that, as far as was ascertained, about fifteen of the physicians of this city employed the metric system exclusively in their prescriptions ; others use it to some extent ; it is used in the Buffalo General Hospital, the Marine ward in the Sisters of Charity Hospital, and, to some extent, in the Fitch Dispensary and other charitable institutions.

The committee asked that, in order to obtain more complete information, they be empowered to send a circular to each member of the society ; also that some formal action be taken endorsing the use of the metric system together with the apothecaries' system.

Upon motion the committee was authorized to issue such circular and the necessary appropriation for the purpose ordered.

Dr. HERMAN MYNTER then read a paper entitled, Senile Gangrene. (To be published in a later issue of the JOURNAL.)

The society then adjourned.

HARLEM MEDICAL ASSOCIATION.

Reported by A. H. LEARY M. D., Secretary.

STATED meeting, December 2, 1891, Dr. M. C. O'BRIEN, President, in the chair.

Dr. G. H. COCKS presented a young man on whom he had successfully operated for tracoma. The lids were rolled over on the forceps and parallel incisions were made with a knife having three blades. A solution of bichloride, 1-500, was then employed to wash the lid and a stiff tooth-brush was also used to rub the solution well into the tissues. Dr. Cocks described another operation sometimes employed which does not require giving ether, being done only under cocaine. This consists of seizing the tracomatous tissue with forceps specially made for the purpose, having flat ends and pressing out the soft material; then using the bichloride solution to wash the lid over the space operated on. A number of sittings are, however, required.

Dr. FRIDENBERG: The case presented is a very good result. These cases of tracoma must be kept from institutions for fear of contagion; hence, any method of treatment which will insure a speedy recovery is useful so the patient may return to the institution. It is said that in Belgium alone there are some 4,000 cases of tracoma, the subjects being practically blind. I consider the treatment by scarification, as described in Dr. Cock's case, the best, as it requires but a few days' rest afterward and the patient can return to work. I have not been able to have the patient submit to the manipulation of squeezing and pressing with the forceps, even under cocaine. This latter plan of operation requires a long treatment and much waste of time. The radical treatment can be done by any practitioner.

Dr. T. H. MANLEY, in making some remarks on umbilical hernia, stated this condition is found nearly always in the female and mostly after labor. It has never been my experience to observe an inguinal or femoral hernia to result from labor. Recently I met a case of hernia in a man situated just above the umbilicus, which

was said to have existed twenty years. Recently he had colicy pains and, two weeks ago, symptoms of strangulation. The tumor increased in size, and vomiting and constipation ensued; but the vomited material did not become stercoracious. Under the hypodermics of morphia and hot applications the symptoms subsided without operation.

During the past year I was called to see a woman, sixty-five or seventy years of age, who was being treated by her physician for gastralgia. The vomiting took on a stercoracious character, and when I saw her she was in collapse. On examination an incarcerated umbilical hernia was found. The condition of the patient did not admit of operation, and a few hours later she died.

A woman recently came under my care at the Harlem Hospital suffering from umbilical hernia which, she stated, followed the birth of her sixth child. The tumor had gradually grown in size, and frequently gave symptoms of strangulation. Her physician had treated her with mild saline purgatives, with temporary relief, but the attacks became so frequent and painful that she desired operation. This case illustrated the fact that the hernial mass in the umbilical variety has no peritoneal covering, being covered by cellular tissue only. After cutting through the stretched and thinned integument, the gut and omentum were found in a pouch between the aponeurotic membrane and integument. The adhesions were very intimate. The stump of the omentum dropped into the abdominal cavity by the slipping off of the ligature, and a large amount of blood was lost. The incision was extended when three large blood-vessels were found requiring ligatures. These were easily secured. A favorable result followed the operation.

Dr. Manley then presented to the Association a colored woman on whom laparatomy had been performed some three years ago, for what exact condition she was unable to state. A large hernial tumor, the size of an adult head, occupied the situation between the umbilicus and the pubes in the median line. The incarcerating ring is small and the periods of strangulation are frequent and very painful. Hence, her urgent desire is for operation, which I expect to perform in a few days.

Dr. Manley further related a case of uterine fibroid, in which metrorrhagia was a distressing symptom. The attending physician had employed every known method of treatment, including electricity. This latter plan had been useful in numbing the pain, but had not reduced the size of the tumor. The patient was obliged

to give up her situation and seek more radical treatment. I discovered a mass within the uterus the size of a cocoanut. All the organs were firmly bound down in the pelvis. While recognizing the seriousness of the operation of abdominal hysterectomy, I was about to advise this operation when I bore in mind a similar case coming under my observation some five years ago, in which the cervix was dilated and the mass was successfully removed by sections—a permanent cure resulting. Therefore, in this case, tents were used until two fingers could be introduced through the cervix, when some two tablespoonfuls of material were scraped off. This was repeated a number of times, and the vulsellum forceps were employed to remove one or two portions as large as an orange. A sanguineo-serous discharge continued for some time, but the uterus gradually assumed the normal size. Payon makes mention of 125 cases he has operated on with this method with only three deaths resulting from the operation. This does not, however, give any assurance of the ultimate result of the disease.

Dr. Wilbur F. Martin: I have recently had considerable success in treating two cases of uterine fibroid with electricity, employing a mild current of about 100 milliampères. The tumors are being gradually reduced in size.

Dr. Manley presented a specimen of the vertebral column taken from a young man who had fallen from a ladder at a height of seventy feet. No vertebral bones were broken, but there was extensive ecchymosis over the cervical region, due to concussion. The patient was paralysed below the shoulders, and felt as if a rope were tied around his body. After death a clot was found between the duramater and body of the vertebræ in the cervical region, and this produced fatal pressure on the spinal cord. The vessels of the cord and the cord itself were uninjured. I have seen this condition to exist in other cases, and I am confident this is the usual way a fatal result is produced, when the bones are not fractured, and the cord thus injured by the fragments.

Dr. Manley also exhibited a specimen of a popliteal artery, five days after being tied for an amputation at the knee-joint. The patient had received very extensive fractures and dislocations from being caught in revolving shafting, and died of septicemia. The clot in the specimen exhibited was firm and undergoing organization.

Dr. R. J. STANTON read a paper on

A CASE OF SPINA BIFIDA OBSTRUCTING LABOR.

On the morning of August 23, 1891, I was called to attend Mrs. G. in confinement. She was twenty-six years of age. This was to be her first child, and she said that she was not expecting her labor for six weeks to come, and knew of no reason why it should be premature. She had been in excellent health all along, and, with the exception of edematous feet and legs, appeared to be in good condition. I was called at nine in the morning. She had been having pains since seven, having passed a very good night, sleeping until awakened by the pains. Upon examination I found the os pretty well dilated, but not entirely so ; high up I also found a pair of feet presenting. As the pains were weak and infrequent, I left, telling the nurse to send for me in case the pains grew stronger and increased in frequency, or in case a foot should come down. One hour afterward I was sent for, the husband telling me that a foot had been born. Upon my arrival I found the left foot and leg as far as the knee had been born. I had hardly time to get my coat off when the mother complained of a peculiar feeling coming over her. Her face gradually blanched, she grew restless, throwing her hands and arms about, yawned, grew thirsty, the pulse at the wrist grew more and more feeble, until it was scarcely to be felt at all. In a word, she had all the signs of collapse, and it alarmed me, as I saw absolutely no cause for such a condition. I resolved to deliver her as rapidly as possible. I brought down the other leg, and with steady traction endeavored to extract the trunk. It came with increasing difficulty until the breech was passed, but further traction caused the mother such terrible agony that I saw that some obstruction existed somewhere. Passing my fingers under the child's back and between it and the posterior vaginal wall of the mother, they came in contact with something giving precisely the impression of a tense bag of waters. I then found that the more traction was exerted upon the child the lower and firmer did this bag of waters, or whatever it might prove to be, wedge itself between the mother and child, thus very effectually preventing the delivery of the latter and causing excruciating pain to the former. In the meantime the mother seemed to be in a very precarious condition. At times she would have severe chills, and at other times would lie in a semi-comatose state.

I plied her with brandy, digitalis, and other stimulants, and after a while she rallied. I was of the opinion that it was a case of concealed hemorrhage, and that the fluid contained in the tense tumor or sac was blood, but what it was that formed the walls of the sac I was at a loss to determine. At this stage of the proceedings I thought it well to have the opinion in the case of someone more skilled than I, and, accordingly, my friend, Dr. James A. J. O'Brien, was sent for and shortly after arrived. He examined and, while not agreeing with my diagnosis,

conceded that it was a case which easily admitted a difference of opinion. He thought that it might possibly be a monstrosity of some sort, which in the end proved to be nearer to the truth than did my idea. However, whatever the diagnosis, the treatment was clear enough, which was to rupture the sac and complete the delivery as soon as possible. I first inserted a hypodermic needle up into the sac and withdrew a syringeful of a straw-colored fluid, proving that my idea, at any rate, was not the correct one. The sac was then ruptured, and fluid gushed out to the extent of almost filling a quart vessel. After the sac had been emptied, the rest of the delivery was easily enough accomplished. The placenta showing no disposition to follow, was extracted with the hand, proving to be a very small one, not more than one-half the usual size and somewhat fatty, besides appearing torn and macerated, although it had been not adherent, and no violence had been done while extracting it. The hemorrhage was very slight, not more than in an ordinary case. The uterus contracted well and the woman went on to recovery without any complications of any kind.

Upon examining the fetus, the cause of the obstruction to the delivery was at once apparent. The child, a female, was dead and evidently had been so for some days. Its weight was about seven pounds, but it appeared to be a full term child. The parietal bones seemed to be somewhat abnormally developed in size, while the occipital bone was entirely wanting. Over the space left by the absence of the occipital bone was a spina bifida sac, its walls composed of a continuation of the scalp shading downwards into the integument of the neck, and the sac extending downwards to the fifth or sixth cervical vertebra, being attached to the spinal column to that extent. Its attachment was constricted like a neck, while the sac itself was round like a cocoanut and about the same size—that is, somewhat larger than the child's head. The child seemed to be normally developed otherwise, with the exception of the lower jaw, which was retreating, and did not seem to have reached its full development, while inside of the mouth the jaws, instead of being covered by the gums, were of a light colored cartilage, giving the child the appearance of having a mouthful of teeth. The spina bifida sac, of course, explained the difficulty in the delivery, but what it was that caused the almost total collapse of the mother I am still at a loss to explain. It may have been due to fright, pure and simple, as the nurse was a novice, and upon seeing a foot appear was very much alarmed, not knowing what to think, and this alarm may, in a measure, have been shared by the young mother. I know of no other plausible explanation.

My reason for reporting this case is very simple. To me it was an exceedingly interesting one, and extremely profitable as well. Cases of spina bifida obstructing labor have been reported before,

but they are still so exceedingly rare, that when the obstetrician is confronted by such a case, he is not always apt to think of such a complication, and, therefore, it is well that such cases be reported from time to time, so that the possibility of such complications may be kept well in mind. Therefore, I report the present case with the hope that it may prove of value to others as it has to me.

Dr. A. H. Leary related a case of spinal bifida which very recently came under his observation, where the covering of the tumor, which was as large as an orange, exuded blood. The integument was as thin as tissue paper. It collapsed the seventh day after birth, and the infant was found dead. No convulsions were noticed. The previous history of the mother was very bad, she having been treated some five years before with very extensive scrofulous abscesses.

Dr. Malleson described a case coming under his notice, in which the vertebræ were mostly composed of cartilage, there being only a few bony centers. It was learned that the mother suffered from chronic peritonitis and very frequent attacks of rheumatism. The family record was bad as far back as could be learned.

Dr. Stanton stated he did not know the previous history of his case, as he had only attended the patient during the time of her delivery.

Dr. O'Brien had seen three cases of spinal bifida, and in all there was a tubercular history.

Dr. A. Chevalier read a paper on

A CASE OF PERNICIOUS ANEMIA.

I was called, on the 22d of last March, to see Mr. W. He gave the history of being fifty-four years old, an Englishman by birth, a salesman by occupation. He drank ale in moderation, but otherwise his habits were temperate. His family history was good, each of his parents being over seventy years of age, and still healthy.

He had never required the services of a physician before, and had always regarded himself as perfectly healthy until about three weeks before he sent for me. He then began to notice that he was becoming very pale, and that he was more easily fatigued than usual, and that he had difficulty in going up stairs, having to stop frequently on account of dyspnea and palpitation. The symptoms had gradually grown worse, and he had fallen from an attack of vertigo while going up one flight of stairs on the night that I first saw him.

On examination I found him to be a well-proportioned man, of 170

pounds weight, five feet nine inches tall. The most remarkable thing in his appearance was his extreme paleness, his lips, tongue, and conjunctivæ being almost bloodless, and his skin was of a pale straw color His temperature was 100½, his pulse full, soft and regular, beating about 104 a minute while he was lying down.

There was marked pulsation of the carotids, and a loud anemic murmur could be heard over those blood-vessels. It could be heard also at the base of the heart and with less intensity at the apex. His heart seemed normal in size and location. His lungs, liver, and spleen also seemed to be normal. His urine was light amber in color, sp. g. 1014, acid, and at this time contained no albumin. Up to this time his appetite had been good, and his bowels were regular.

There was no edema, petechia spots, or retinal hemorrhage, although the optic disc was much paler than in health. In order to get enough blood to moisten a slide for examination, it was necessary to make a long incision into the finger and then use pressure toward the wound. The blood was light in color, leaving a lemon-colored stain on a piece of white linen. On examination the red corpuscles were very much reduced in numbers. In shape they were irregular, and in size they varied from being twice as large as normal to others not more than one-third to one-half the usual size of a red corpuscle.

The white corpuscles showed nothing unusual. They seemed slightly increased as compared to the red, but for the mass of the blood there was probably a slight diminution.

The patient was put under treatment, and for a period of about two weeks he became steadily worse. His temperature varying from 100 to 103, his pulse beating about 120, slight edema of the feet and legs, and more marked prostration, so that he was obliged to keep his bed most of the time. During this time he suffered from anorexia, but no nausea or distress after eating, and his bowels continued to move but once a day. He now had three attacks of epistaxis, in each of which there was slight oozing of blood for from six to twelve hours. On the 5th of April his appetite began to return, the slight edemia disappeared, his fever gradually lowered until the last of April, when it became normal, his pulse now beating about eighty a minute, and he expressed himself as feeling strong, and determined to return to work, which he did on the first of May, although his complexion, blood and anemic murmurs remained as when I first saw him, and he complained of dyspnea when going up stairs the length of those at the 125th Street and 8th Avenue elevated station. During May he was at business from eight to five each day and felt fairly good, but at the beginning of June his anorexia and weakness returned, and he was obliged to keep his room.

Now for a period of two weeks he passed out from under my care.

When he sent for me again, on the 16th of June, I found him very

much prostrated. His feet and legs were very much swollen, his fever was 102, and his urine now contained about ten per cent. of albumin.

He was at times delirious and his appetite was entirely gone. He remained in this condition for about one week, when a severe diarrhea occurred. The first of his sickness came on, the edemia disappeared, and his mind became clear. At this time he had two more attacks of epistaxis. His temperature fell to ninety-seven, and he expressed himself as feeling much better. His appetite, however, did not return, and his diarrhea continuing, he died of asthenia on the 12th of July. A post-mortem was not allowed.

The principal features of the case that have interested me was, first, the etiology. It is quite common under the age of forty, especially in females, where it may follow parturition or exhausting discharges. It also frequently follows stomach or intestinal disorders and tape-worm. It is also frequently seen in insane asylums, where it follows mental worry, but in this case it must be regarded as purely idiopathic in a man of fifty-four of a sanguine happy disposition.

Another point of interest was the slight amount of alimentary disturbance during the course of the disease. He never suffered from nausea or vomiting. Anorexia was not marked until the last three weeks, and there was no diarrhea until the last seventeen days.

Another point was the period of remission of the disease. I think if I had more strongly urged rest during the month of May, instead of allowing him to return to work, that his life might have been prolonged several months, although the final ending of the disease would probably have been the same.

And, lastly, the slight amount of hemorrhage. He had epistaxis five times, but there were no ecchymotic spots or retinal hemorrhages.

Dr. Martin related a case which had recently went the rounds of the hospitals. Pernicious anemia had been diagnosticated and treated accordingly, but with what success he could not state, as he had recently lost sight of the patient. A very interesting fact connected with this case was that there was a universal alopecia. Scarcely a hair could be found over the whole body.

The Buffalo Medical Journal

It is to be deplored that so many excellent medical journals offend good taste by publishing interleaved advertisements.

[*From the Buffalo Illustrated Express.*]

DR. ROBERT P. BUSH,

Speaker of the New York State Assembly, 1892.

BUFFALO MEDICAL AND SURGICAL JOURNAL

A MONTHLY REVIEW OF MEDICINE AND SURGERY.

EDITORS:

THOMAS LOTHROP, M. D. - - WM. WARREN POTTER, M. D.

All communications, whether of a literary or business character, should be addressed to the managing editor: 284 FRANKLIN STREET, BUFFALO, N. Y.

VOL. XXXI. FEBRUARY, 1892. No. 7.

THE PHYSICIAN IN POLITICS.

DR. ROBERT P. BUSH, of Horseheads, who was elected Speaker of the New York State Assembly, January 5, 1892, has the distinguished honor of being the first physician who has ever held this high office. He was chosen by the unanimous vote of his party, in caucus, to preside over the most important popular legislative body in the United States, next after the House of Representatives. Physicians throughout the State and nation should take pride in the fact that a regular practitioner of medicine, who has won an honorable name in his profession, has been accorded such distinction by his political associates.

Dr. Bush was born in Yates county in 1842, and, therefore, it is in the ripest period of his manhood that he assumes the Speaker's gavel. His preliminary education was obtained at the academies in Franklin and Cortland, and he graduated from the Medical Department of the University of Buffalo in the class of 1874. He has been in the active practice of his profession since that time, excepting during the Winters that he has spent in the Assembly, where he is now serving his seventh term.

Dr. Bush is also a veteran of the late war, with an honorable record, having served as a private in the 12th Regiment of New York Infantry during the first two years of the war. He was commissioned as Captain in the 185th Regiment of New York Infantry, September 17, 1864, promoted to Major, December 3, 1864, and mustered out with his regiment May 30, 1865. He participated in the battle of Bull Run, was at the siege of Yorktown, and in McClellan's peninsular campaign, including the seven days' fighting before Richmond, and in the battles of Antietam and Fredericksburgh. He was taken prisoner at Hatcher's Run,

October 27, 1864, but was exchanged promptly, and participated in the final campaign of the Army of the Potomac, that practically ended at Appomattox C. H., April 9, 1865.

We publish in this number an excellent picture of Speaker Bush, for which we are indebted to the Buffalo *Illustrated Express*.

EDITORIAL MELANGE.

The American Pharmaceutical Association, together with the state and local pharmacy organizations, are uniting to hold an auxiliary congress during the World's Columbian Exposition in Chicago, in 1893.

The Chairman of the Pharmaceutical Committee, Dr. Oscar Oldberg, has issued a very courteous letter, asking pharmaceutical, chemical and medical journals to assist in giving publicity to the call, and we cheerfully comply with this request. It is to be hoped that a scientific *esprit de corps* will be stimulated by the Columbian Exposition that will pervade every department of applied science.

Dr. Oldberg's committee has issued an elaborate address, which every pharmacist should read.

The Food Manufacturers' Association of the United States proposes to hold a Food Exposition at Madison Square Garden, New York, in October, 1892. This forms a part of a comprehensive plan to celebrate the 400th anniversary of the discovery of America throughout the country, and it is to be commended as one of much merit, and one which will result in much good to the people. Only food products will be allowed on exhibition at this unique fair. It will be the first of the kind ever held in the world. It is hoped that every resident of the State of New York, in particular, will be interested in the exposition, but the people of the whole United States cannot fail to take interest in any attempts to improve the quality of our food, and to elevate and maintain a standard of purity and wholesomeness in regard to our food products.

The College of Physicians of Philadelphia announces that the next award of the Alvarenga Prize, being the income for one year of the bequest of the late Senor Alvarenga, and amounting to

about one hundred and eighty dollars, will be made on July 14, 1892. Essays intended for competition may be upon any subject in medicine, and must be received by the secretary of the College on or before May 1, 1892. It is a condition of competition that the successful essay, or a copy of it, shall remain in possession of the College.

The New York Post-Graduate Hospital, including the babies' ward, has courteously sent us its seventh annual report, for the year ending September 15, 1891. The members of this corporation embrace some of the most distinguished business men, divines, lawyers, and physicians in the city of New York, and the officers of the hospital are chosen especially for their proficiency. The directors may well take pride in the showing made in this report, both with reference to the conduct of the hospital itself, as well as to its financial condition. We are sure the Post-Graduate will continue in the future, as in the past, to maintain a standard that will command the respect and confidence of the profession throughout the entire Union.

The *Medical Fortnightly*, edited and published by Dr. Bransford Lewis, in St. Louis, Mo., made its appearance with the beginning of the year. It is rarely that a new journal presents such an excellent first number; it teems and bristles with bright sayings of great professional interest, and shows in its dress and make-up, as well as its editorial conduct, that it has an experienced hand at the helm. We bespeak for this handsome magazine a bright and successful future.

The *Southern Medical Record* presents itself in a fine dress to celebrate the beginning of the year 1892, and adds to its editorial staff two of the most celebrated surgeons of the South, Dr. J. McFadden Gaston, and Dr. Willis F. Westmoreland, of Atlanta. These two distinguished teachers and writers will add a tower of strength to this excellent magazine.

The names of Drs. Nicholson and Stockton, who formerly belonged to the editorial staff, have retired from its pages, on account of pressing duties in other directions.

The *Southern Practitioner*, edited by that veteran, Dr. Deering J. Roberts, of Nashville, made its appearance in January with a hand-

some new dress, and with an enterprising spirit pervading its pages, which indicates that its accomplished and experienced editor does not intend to be outdone by any magazine in the Southwest. We always welcome the *Southern Practitioner* to our table, and we congratulate its editor upon the progressive spirit which he has manifested.

Messrs. William Wood & Company announce that the further publication of the Medical and Surgical Monographs will cease with the issue of the number for December, 1891, but the thirty-six numbers, comprising twelve volumes, can be purchased either in separate numbers, price $1 each, or as bound books, containing three numbers each, as issued. A prospectus containing prices, description of binding, and terms of sale of the bound form of the work, will be sent upon application to the publishers.

Wood's Medical and Surgical Monographs are not supplied through the book trade on any terms. All orders should be sent direct to William Wood & Company, Medical Publishers, New York.

A Unique Magazine.—A unique experiment will be tried in the February issue of *The Ladies' Home Journal.* The entire number has been contributed in prose, fiction and verse, by the daughters of famous parentage, as a proof that genius is often hereditary. The work of thirty of these "daughters" will be represented. These will comprise the daughters of Thackeray, Hawthorne, Dickens, James Fennimore Cooper, Horace Greeley, Mr. Gladstone, President Harrison, William Dean Howells, Senator Ingalls, Dean Bradley of Westminster, Julia Ward Howe, General Sherman, Jefferson Davis, and nearly a score of others. Each article, poem or story, printed in this number has been especially written for it, and the whole promises to be a successful result of an idea never before attempted in a magazine.

Announcement.—E. B. Treat, Publisher, New York, has in press for early publication the 1892 International Medical Annual, being the tenth yearly issue of this deservedly popular work.

Its corps of thirty-five editors are specialists in their respective departments, and have been carefully selected from the brightest and best American, English, and French authors.

It is the embodiment of what is worth preserving of the current medical journals of the world for the year, and will contain over 6,000 references to diseases and their remedies.

The service rendered the profession by this Annual cannot be overestimated, and it is an absolute necessity to every physician who would keep abreast with the continuous progress of practical medical knowledge.

This Index of New Remedies and Dictionary of New Treatment, epitomized in one ready reference volume at the low price of $2.75, makes a desirable investment for the busy practitioner, student and chemist.

Dr. W. E. B. Davis, late of Birmingham, Ala., has removed to Rome, Ga., to join his forces with Dr. J. B. S. Holmes in the conduct of the largest and most completely equipped sanitarium in the South, devoted exclusively to the treatment of diseases of women. The temptation must have been a very strong one to induce Dr. Davis to abandon his large and lucrative practice in Birmingham, but we have no doubt that he will find in his new home, and in the new relations which he assumes, a more congenial field, where he can cultivate his peculiar fitness and taste for the practice of abdominal surgery to its fullest extent. Dr. Davis is easily and properly regarded as the foremost abdominal surgeon in the mid-south, and is also one of the most popular and progressive physicians of the age. His ideal is a high one, and it would benefit the whole profession if it should follow Dr. Davis's standard and aim to reach its high pinnacle.

The Transactions of the American Association of Obstetricians and Gynecologists, Vol. IV., 1891, is now ready for delivery. It is a handsome standard octavo, bound in half Russia and cloth, similar to the preceding numbers, is handsomely illustrated, and in every way maintains the high standard of its predecessors. Price, cloth, $5.00; half Russia, $6.00. The edition is limited, and orders should be placed with the undersigned at once, as it will not be possible to obtain the volume a few months hence.

WILLIAM WARREN POTTER, M. D., *Sec'y*,
284 Franklin street, Buffalo, N. Y.

The Medical Society of the State of New York will hold its eighty-sixth annual meeting at the City Hall, in Albany, Tuesday,

Wednesday, and Thursday, February 2d, 3d, and 4th, under the presidency of Dr. A. Walter Suiter, of Herkimer. The annual banquet of the Society will take place at the Delavan House, Wednesday evening, February 3d.

It is anticipated that this will be one of the largest meetings the Society has ever held, and it is requisite that those who expect to attend shall be expeditious in securing their hotel accommodations. A number of distinguished gentlemen from outside the State will be present to add to the interest of the occasion.

The restraining by statutory law of the commerce in poisonous drugs, such as opium, cocaine and chloral, is *correct* in principle, and should receive the endorsement of every citizen who has respect for human life. We hope to see a bill passed in our state legislature that will prevent the sale of such drugs except upon the prescription of a physician.

Dr. Ferdinand King, of New York, has severed his relations with the *International Journal of Surgery*, and established the *Doctors' Weekly*, which is a strictly medical newspaper. It is a bright and handsome sheet that deserves to succeed. It has our best wishes, at any rate, whatever they may be worth. It is published at 33-39 Gold street, New York, where subscriptions should be sent, addressed to Dr. King.

The Harvard Medical School Association has published its Bulletin No. 1, which comprises a report of the first annual meeting, held in Boston, June 23, 1891. This is a handsomely printed book of fifty-two pages that every alumnus of a school should possess, and if there are any who have not received it, they can obtain it by sending their names to Dr. R. W. Lovett, Secretary, No. 379 Boylston street, Boston, Mass.

BULLETINS OF THE PAN-AMERICAN MEDICAL CONGRESS.

[OFFICIAL.]

THE INTERNATIONAL EXECUTIVE COMMITTEE OF THE PAN-AMERICAN MEDICAL CONGRESS.

The Committee on Organization of the Pan-American Medical Congress, at its meeting at St. Louis last October, elected the following International Executive Committee: *The Argentine Republic*, Dr. Pedro Lagleyze, Beunos Aires; *Bolivia*, Dr. Emelio Di

Tomassi, La Paz; *Brazil*, Dr. Carlos Costa, Rio de Janeiro; *British North America*, Dr. Jas. F. W. Ross, Toronto; *British West Indies*, Dr. James A. DeWolf, Port of Spain; *Chili*, Dr. Moises Amaral, Santiago; *United States of Colombia*, Dr. P. M. Ibañez, Bogota; *Costa Rica*, Dr. Daniel Nuñez, San José; *Ecuador*, Dr. Ricardo Cucalon, Guayquil; *Guatamala*, Dr. José Monteris, Guatemala Nueva; *Haiti*, Dr. D. Lamothe, Port au Prince; *Spanish Honduras*, Dr. George Bernhardt, Tegucigalpa; *Mexico*, Dr. Tomas Noriega, City of Mexico; *Nicaragua*, Dr. J. I. Urtecho, Grenada; *Peru*, Dr. J. Casamira Ulloa, Lima; *Salvador*, Dr. David J. Guzman, San Salvador; *Spanish West Indies*, Dr. Juan Santos Fernandez, Habana; *United States*, Dr. A. Vander Veer, Albany, N. Y.; *Uruguay*, Dr. Jacinto De Leon, Montevideo; *Venezuela*, Dr. Elias Roderiguez, Caracas.

Hawaii, Paraguay, Santo Domingo, the Danish, Dutch and French West Indies are not yet organized. Nominations of local officers have been received from a majority of all the members of the International Executive Committee, and a number of the lists have been confirmed by the Committee of Organization. These will be announced as rapidly as acceptances are received.

CHARLES A. L. REED, *Secretary-General.*

CINCINNATI, January 15, 1892.

THE PAN-AMERICAN MEDICAL CONGRESS IN THE UNITED STATES OF COLOMBIA.

PURSUANT to nominations by Dr. Pedro M. Ibañez, of Bogota, member of the International Executive Committee for the United States of Colombia, the following organization of the Pan-American Medical Congress has been effected in that country: *Vice President*, Dr. Pio Rengifo, New York; *Secretaries of Sections—General Medicine*—Dr. Ignacio Guterres Ponce, Paris; *General Surgery*, Dr. Rafael Rocha Castilla, Bogota; *Military Medicine and Surgery*, Dr. Abraham Aparicio, Bogota; *Obstetrics*, Dr. Joaquin Maldanado, Bogota; *Gynecology and Abdominal Surgery*, Dr. José M. Buendia, Bogota; *Therapeutics*, Dr. Manuel Plata Azuero, Guaduas; *Anatomy*, Dr. Joan D. Herrara, Bogota; *Physiology*, Dr. Antonio Bargas Vega, Bogota; *Pathology*, Dr. Nicolas Osorio, Bogota; *Diseases of Children*, Dr. Ant. Gomez Calvo, Bogota; *Ophthalmology*, Dr. Proto Gomez, Bogota; *Laryngology and Rhinology*, Dr. Luis Fonnegra, Bogota; *Otology*, Dr. Carlos

Esguerra, Bogota; *Dermatology*, Dr. Daniel E. Coronado, Bogota; *Orthopedics*, Dr. Juan E. Manrique, Bogota; *Naval Hygiene and Quarantine*, Dr. Gabriel I. Castaneda, Bogota; *General Hygiene and Demography* ——; *Mental and Nervous Diseases*, Dr. Pablo Garcia Medina, Bogota; *Oral and Dental Surgery*, Dr. Guillermo Vargas Paredes, Bogota; *Medical Pedagogics*, Dr. Jorge Vargas, Bogota; *Medical Jurisprudence*, Dr. Leoncio Barret, Bogota.

Auxiliary Committee (each member being the official representative of the Congress in his respective city): Dr. Nicolás Osorio, Dr. Andris Posada Arango, Dr. Jorge E. Delgado, Dr. Eugenio de la Hoz, Dr. Domingo Cagiao, Dr. José Manuel Rodriguez, Dr. Paulo Emelio Villar, Dr. Felix M. Herández, Dr. Rafael Calvo, Dr. N. Ribôn, Dr. Milceades Castro, Dr. Cayetano Lombana, Dr. José M. Martinez, Dr. Isaias Saavedra, Dr. Severo Forres, Dr. N. Villa, Dr. Everisso Garcia, Dr. Miguel Caicedo, Dr. Emilio Villamizar.

The following medical societies have been elected as auxiliaries of the Congress, *viz.: Academia nacional de Medicina, Academia de Medicina de Medellin, Sociedad de Medicina del Cauca.*

The following journals have been designated as official organs of the Congress, *viz.: Revista Medica, Bogota; Revista de Higiene, Bogota; El Agricutor, Bogota; Boletin de Medicina del Cauca, Cali; Anales de la Academia de Medicin de Medellin, Medellin.*

The expressed wish of the profession of the United States of Colombia is for a date of meeting during the Colombian Exposition.

CHARLES A. L. REED,
Secretary-General.

CINCINNATI, January 17, 1892.

Book Reviews.

REGIONAL ANATOMY IN ITS RELATION TO MEDICINE AND SURGERY. By GEORGE MCCLELLAN, M. D., Lecturer on Descriptive and Regional Anatomy at the Pennsylvania School of Anatomy; Professor of Anatomy at the Pennsylvania Academy of the Fine Arts; Member of the Association of American Anatomists, Academy of Natural Sciences, Academy of Surgery, College of Physicians of Philadelphia, etc. Illustrated from photographs taken by the author, of his own dissections, expressly designed and prepared for this work, and colored by him after nature. "L'anatomie n'est pas telle qu'on l'enseigne dans les ecoles."—Bichat. In two quarto volumes. Vol. I. Philadelphia: J. B. Lippincott Company. 1891.

No one can read Prof. McClellan's Regional Anatomy without having two conclusions impressively forced upon him, viz., that the author is a most excellent and practical anatomist, and that he has little or no sympathy with the methods of imparting anatomy to students ordinarily used by teachers of this branch of science. There can no longer be any doubt that regional anatomy, the anatomy of the different regions of the body considered in the relation of their various parts to one another, is the only scientific, and therefore the only practical and profitable way for the teacher to present, and the student to study, this fundamental science. We were very glad, therefore, when we learned that the author was doing for American practitioners and students what Treves and Tillaux, for example, have done so well in the old world. That he has succeeded, no one can doubt who reads this magnificent work.

Vol. I. is concerned with the head and upper regions of the body, including thorax and upper extremity. The head alone is given sixty pages, and is quite typical of the thoroughness which characterizes the work. Beginning with the surface landmarks of the skull, each portion of this region is described as successive dissections have brought the various planes into view. Wherever an application of anatomical knowledge can be made to medicine or surgery, the author has made it. Especially interesting and valuable in this connection are those pages devoted to the topography of the brain. No part of the work shows the happy combination of anatomy and surgery in the author better than his remarks upon localization of lesions from the operative standpoint. He says, "That the results of operative interference with the brain-structure should so often verify diagnosis, is cause for wonder, when one considers the uncertain features of the anatomy of localization. Repeated examinations of the relations of the fissures to carefully mapped-out points, after removal of a disc of bone on the heads of many cadavers, have shown the author the fallacy of depending solely upon measurement, and the importance of making the artificial opening in the skull large enough to enable the operator to see the parts exposed." We think this quite coincides with the experience of surgeons who have had to do with this class of cases.

The ear, eye, nose, face, mouth, larynx, and neck are in turn considered, with their immediate surrounding regions, and wherever a plate serves to illustrate the text, it is found. Especially hand-

some and clear are the plates showing the various structures of the neck, and, together with the excellent text descriptive of this important region, this portion of the work will prove of decided value to the reader.

The chapter upon the Thorax is also very complete, and contains many practical suggestions whereby the anatomy of this region may be turned to clinical use, and the same remark applies with equal force to the treatment of the upper extremity, which forms the closing chapters of this volume.

The dry and uninteresting descriptions, from the medical student's standpoint, which so abound in the average text-book that is put into his hands, are nowhere found in this book. The style is clear, easy, and simple, and such refinements as tend only to confuse, the author has judiciously omitted. While it is often apparent that the author has read and extracted the meat from the standard writers upon practical anatomy, still the effect of the book, as a whole, is that it is the result of large information derived from actual dissection and mature clinical experience, and these, after all, are the best books.

Beside the method of the work, the next most important feature is found in the character of the illustrations. These aim to be exact representations of the dissections of the author, and to this end the camera has been employed. The parts have been first photographed, and from these the plates were made on stone, the object in employing photography being to reproduce such exact representations of the dissections as would illustrate and verify the descriptions given in the text. Admirable as is the result in general, there are a few plates in the book which are not distinct, and in these instances it seems to us that a diagram would serve a better purpose than the truer but less clear photographic picture. Wherever many different structures are represented in a small space, as for instance the views of the brain, the general effect is not good, and one must strain his eyes to differentiate the various parts. Not so, however, the region of the neck, where, for the most parts, the picture is a model of beauty and clearness. Looked at as a whole, the book is a great credit to the author and a most handsome and elaborate specimen of book-making. We always expect the very best from the house of Messrs. Lippincott, but they have, in this instance, done more than fulfil our expectations. The work is worth the price asked, and deserves a widespread circulation among practitioners and students. J. P.

Buffalo Medical and Surgical Journal

Vol. XXXI. MARCH, 1892. No. 8.

Original Communications.

NERVE COUNTERFEITS OF UTERINE DISEASE.[1]

By HENRY D. INGRAHAM, M. D.,
Buffalo, N. Y.,

Professor of Gynecology, Medical Department Niagara University; Gynecologist to the Buffalo Hospital Sisters of Charity.

The object of this paper is to enter a protest, feeble though it be, against the unnecessary or heroic treatment of the uterine organs of women who are suffering chiefly from nervous exhaustion, or a hyperesthetic condition of the nervous system; also, incidentally, to protest against the unnecessary vaginal examination of young unmarried women. I know of no better way to enter my protest, and make myself understood upon these subjects, than to relate, briefly, a few of the many cases which I have seen; and were it not for the cases which have occurred in my own practice, I would not believe that intelligent physicians, some of them giving especial attention to the diseases of women, would recommend, in many instances, the treatment they do. Doubtless, many general practitioners are more inclined to resort unnecessarily to local treatment than the specialist. As far as I know, Prof. Goodell is the only writer of a text-book upon the diseases of women who devotes any particular attention to the Nerve Counterfeits of Uterine Diseases, as he designates the class of cases to which reference is made. Yet many of the best men in the country, through the columns of the medical journals, have protested against the local treatment of the female generative organs, and the mutilation of women when there is no organic lesion. One would think that enough had been said upon these subjects so that cases like the ones about to be related would be unknown, yet they occur frequently even at the present day.

Case I. About three years ago I was called, in consultation, to see Mrs. A., aged thirty-eight, married eighteen years, one child seventeen

1. Read at the meeting of the Buffalo Obstetrical Society, November 24, 1891

years old. Menstruated first at fourteen, regular, but always suffered from dysmenorrhea. Never had rugged health, but has been worse since the birth of her child; had pains in both iliac regions, more marked in the right; pains in the back, extending down the thighs, in back of neck and head, with dyspeptic symptoms and constipation. The dysmenorrhea had been worse since the birth of the child, and much worse for the past four or five years. She had severe pains in the back and sides one week before the menstrual period, during the period, and a week after, so that she was comfortable only about one week in each month. Upon vaginal examination, the uterus was found to be slightly retroflexed, yet not enough to account for the dysmenorrhea or other pains. There was no disease of the appendages, as far as could be discovered.

The patient had been under the care of several physicians, and had received all manner of treatment. She was formerly, for a long time, a patient of the late Prof. White. Her present physician had attended her for a year or more, and he fully believed if her ovaries were removed she would regain her health. After a thorough examination, I concurred in his opinion. A few weeks later she entered the Buffalo Hospital of the Sisters of Charity, and I removed her tubes and ovaries. Neither were diseased to any extent. She made a good recovery, ceased to menstruate, and for several months was quite well, but for the past two years her health has been but little better than before the operation, except she does not have the dysmenorrhea, because she does not menstruate: otherwise her condition is very much as before the operation.

Case II. Mrs. L. E., aged thirty-nine, American, married seventeen years, no children. Menstruated first at fourteen, usually regular, occasionally slight dysmenorrhea. Health good until five years ago, when it began to fail. She had pains in the back, both iliac regions, more especially the left, the hypogastrium, and head. Menstruation somewhat painful, had leucorrhea, bowels constipated, appetite poor, and restless at night. Was able to do the greater part of her housework, her family consisting of herself and husband. She had been treated by several physicians for various diseases, for three years, without any marked improvement, sometimes better, at other times worse. Two years ago the first of last January, she had her tubes and ovaries removed by a celebrated gynecologist, and I understand there was no morbid change to be discovered in these organs by the naked eye, after their removal. She made a good recovery from the operation, and for a few months was much improved, yet not free from pain in the back and left iliac region at any time. Six months after the operation she was worse than before it was performed, was confined to her bed, able to sit up only a few minutes at a time. The surgeon who operated now

concluded that she had some spinal disease, and called to his aid an orthopedic surgeon, who put her into a sole-leather jacket. Four months later she was no better, and I was called to see her. I found her in bed, unable to sit up on account of the pain in her back and left iliac region. A thorough examination revealed no soreness, tenderness, or deformity of the spine whatever, and it was said that there never had been any. She complained of severe backache, yet she did not flinch under very firm pressure. Pressure in either iliac region caused her to flinch very quickly, unless her attention was called to something else, when she could endure quite firm pressure without noticing it. The uterus was movable, and although she said she had profuse leucorrhea there was no evidence of it, nor any condition of the parts that would indicate its existence. In fact, no lesion could be discovered anywhere. She was informed, if she would go to a hospital and allow a certain treatment to be faithfully carried out, that she would get well. It was intended to give her the Mitchell treatment for nerve exhaustion, but when she was informed what that would be she declined to go, saying that she could not endure it, and that her husband had spent all his money, and she could not afford to go. She wished me to attend her at her house, but I declined, believing that I could do her no good if she remained at home. It is now fourteen months since I saw her, she having left the city. The following is a description of her present condition, furnished by a sister-in-law, with whom she is living, the patient not being able to write. She says:

"While it was warm enough so that Mrs. E. could sit out doors she sat up quite a little, but since it is cooler she does not have strength to sit up scarcely any. The pain in her back and left side is no better than when you saw her. She has a pain and very hot feeling in the top of her head, running down into her face and back of her neck, nearly all the time. Her appetite is good, but her food distresses her, so she has to be very careful what she eats. She still wears the jacket and can't leave it off long enough to take a bath without being worse for two or three days. Has cold feet and legs; can't keep them warm. Black specks float before her eyes all the time. Bowels constipated."

Case III. Miss C. N., aged twenty-two, born in Canada. This patient is a beautiful, highly educated, and accomplished young woman, of medium size and well developed. Always had good health until a little more than a year ago. Menstruated first at fourteen; was somewhat irregular, and the flow was scanty a part of the time, but never suffered from dysmenorrhea. Has been in school continuously. In her twentieth year she was sent to a "young ladies' college," her room being on the sixth floor. She took five and six studies, including music. After a few months her health began to fail. She had headache, pain in the back, also both iliac and hypogastric regions; appe-

tite poor, bowels constipated; slept poorly; menses more irregular and scanty than formerly, and finally she did not menstruate for four months.

At last vacation came, and she was sent into the country to recuperate. She improved somewhat, but was unable to enter school at the beginning of the next term. Later she was considerably better, and, being anxious to finish the course, she again entered school, but had not been there long before her health failed entirely, and she left completely broken down. It is the same old story,—too much study and too little attention to the plainest and simplest hygienic laws. She went home and was under the care of the family physician for some time, but did not improve. As she was suffering from pain in the head, neck, and back, and also from severe paroxysmal pains in either iliac region, impaired appetite, and an extremely nervous condition, complicated with amenorrhea, a physician was called in consultation who does some uterine surgery. After examining the patient, he informed the friends that she had diseased tubes and ovaries, and that the only relief for her was the removal of the offending members. To this the family physician agreed, but the mother objected. The suffering of the patient, from pain in either iliac regions, was terrible. She did not improve, and as the consultant continued to say to the mother, "I told you so," she finally gave her consent for the removal of these organs, and the day for the operation was set. As the time approached, although the patient was no better, the mother changed her mind, and refused to have the operation performed. There was no improvement in the case, and a little later another gynecologist was called. After a thorough examination, he declared that there was no trouble whatever with the tubes and ovaries, but that the poor sufferer had retroflexion of the uterus, complicated with stenosis of the internal os, and endometritis. With the consent of the attending physician and the mother, he forcibly dilated the cervix, under an anesthetic, treated the endometritis, replaced the uterus, and introduced a pessary to retain it in position. Still the patient did not improve; the pains continued as severe as ever. Every afternoon, between three and seven o'clock, they began, sometimes earlier, sometimes later, and lasted well into the night, the patient sleeping but little until three or four o'clock in the morning. When I saw her, the latter part of last August, she had been in bed over three months, was unable to walk, and only able to sit up a few minutes at a time; had no appetite, bowels constipated, yet her tongue was clean, and she had no fever. She still had the same terrible pains in either iliac region, radiating to her back and down her thighs. After a most thorough and careful examination of all the organs, I was unable to discover any trouble whatever with the uterus, tubes, or ovaries, or, in fact, any organic lesion anywhere. The uterus was slightly smaller than normal, but there was no retroflexion.

although the pessary, which had been introduced some time before, could not be borne, and was removed by the family physician three or four days after its introduction. It was noticed that, although the patient had severe pain in either iliac region, and that pressure could not be tolerated, yet, when her attention was diverted, stronger pressure could be made. As she had taken nearly all the anodynes, nervines, and many of the tonics of the pharmacopeia, it was thought best to medicate her as little as possible. Bromides, with chloral, were advised for the pains and sleeplessness; iron, combined with vegetable tonics, to improve the general condition; also the use of electricity, not so much for any specific effect that it might have, but as a nerve tonic. The patient was assured that the use of electricity would, in a short time, control the pains, and that the result would be accomplished much sooner if she made a strong effort to control the pains as far as possible. Systematic feeding was advised, especially to give at regular intervals a certain quantity of milk, so that during the day she should take at least a quart, this amount to be increased, so that in a week or ten days she should take double the quantity. Later on, eggs, beef tea, and other light nourishing diet, to be given in generous quantities. Her bowels to be kept in proper condition. Under no circumstances was she to sit up, except to have her bed made, until the disappearance of the pains. Visitors were not allowed. Her mother, who acted as nurse, was advised to notice her pains as little as possible, and to cheer, by word and example, all she possibly could. This treatment, with slight variations, was faithfully carried out, not because the attending physician had much faith in it, but because every other treatment advised, except the removal of the tubes and ovaries, had been tried and failed, and this was a last resort. In three weeks the patient was free from pain and out of bed. Since then she has steadily improved. At this writing, three months from the time I first saw her, she says she never felt better. She has menstruated twice, freely, without pain, has been out on the street for several weeks, and undertakes any reasonable exertion. She has gained twenty pounds, and hardly looks like the same person.

Several other cases might be reported that I have seen, similar to the ones given, but these are enough to demonstrate the points claimed.

Patient number one had been under the care of several very excellent physicians for a number of years, yet she did not improve, and it was thought if the menopause was brought about her health would improve. It would certainly be to her advantage to be relieved of the dysmenorrhea from which she suffered so severely. For a few months after the operation she was much better, but family troubles occurred, and from that time she was worse, the

old pains in the back and iliac regions returned, and now she is almost as much of an invalid as before the operation, yet she does not suffer as severely, as she has no dysmenorrhea, but the benefit derived from the operation was much less than was expected, both by her medical attendant and myself.

Patient number two had always been healthy until three years before her operation, when she began to fail. She had been married a number of years and had no children; she had pains in her back and sides, so she thought there must be some disease of the reproductive organs. She consulted a physician who believed he discovered diseased tubes and ovaries, and treated her accordingly, but she did not improve, and she consulted others, each finding something different, and telling her that he could relieve her. By far the most competent physician whom she consulted before her operation, told her, after making a thorough examination, that she had no organic disease of the reproductive organs whatever, and that local treatment was doing her more harm than good, that she needed altogether different treatment, and that she could get well. This evidently did not please the patient, as she did not consult him again. After the removal of the tubes and ovaries she improved, because she believed she was relieved of the cause of her trouble, and was elated, thinking from that time on she was to be a well woman. After a time reaction occurred, and she was worse than ever. Then some form of spinal disease was discovered and the sole leather jacket applied. It may be possible for a patient to have some serious disease of the spine without any tenderness or deformity, yet the writer does not believe it. But if it is, the continuous use of a sole leather jacket for eighteen months should at least benefit the patient somewhat if there is any virtue in the jacket. Before the operation the patient did her housework and attended to all her duties, although a partial invalid. Today she is bed-ridden, suffers vastly more pain than before the operation, is able to sit up but very little, cannot walk, and never expects to be any better. Does any one say this patient was improved by the operation?

Patient number three simply broke down from overwork. Her parents and teachers did not realize the fact which should be understood by all who have charge of the young, that the physical development is impaired when the mental faculties are overworked; that the growing girl cannot overstudy, keep late hours, or go beyond her strength in any way, especially at the menstrual period,

without disastrous results. This young woman's nervous system was unduly strained, then came the explosion. It came early enough so that no serious results are likely to remain permanently, except there is no doubt that she will be more nervous in after life than she would have been if this trouble had never occurred. Yet the removal of this young woman's ovaries would have been an irreparable loss, entirely unjustifiable, and possibly one that would have grieved her beyond endurance in later years. Why any intelligent physician should overlook the real disease and accuse a normal ovary as the cause of the trouble is beyond the writer's comprehension, unless he wished to add to the number of his operations without any regard to the well-being of the patient. Neither do I understand why it was necessary to dilate the cervix under an anesthetic, make a half dozen or so applications to the cavity of the uterus, and introduce a retroflexion pessary, which was removed within four days because it could not be tolerated. It does not seem that this treatment was necessary when the patient had never suffered from dysmenorrhea, leucorrhea, or any other symptoms, except pain, that would indicate disease of the uterus or its appendages. Surely such treatment would not restore a retroflexion of the uterus, nor cure an endometritis, that would not disappear under general treatment. I would even go further and say that we are not justified in making a vaginal examination in young unmarried women, unless all other means for their relief have been tried, or there is some urgent necessity for it. Prof. Goodell says "it is committing a moral rape," a sentiment that must be endorsed by all noble-minded physicians. At the present time I have three patients under my care who have been told by competent physicians that their tubes and ovaries must be removed before they could ever be any better. One patient has almost entirely recovered her former health, and the others are well on the road towards good health. I have had several similar cases, besides many who have been treated for displacements, chronic hyperplasia or metritis, endometritis with leucorrhea and dysmenorrhea, who recovered with but little or no local treatment. The symptoms of nerve exhaustion are much the same as those of uterine disease, especially if the woman has any knowledge of the symptoms of real derangements of the uterus. Yet, when the symptoms are out of all proportion to the local lesions, it is usually a pretty sure indication that the trouble is general, not local, and that the treatment to be effective must be general. Then, again, the history of the

case will do much to clear up the diagnosis if it be at all doubtful.

Many are the causes of nerve exhaustion and its ally, hysteria, with its counterfeited symptoms, the most common of which are anything that produces worry or grief, as excessive and prolonged mental strain, whether it be in the school girl, the school teacher, the mature maiden, or the wife, disappointments in love, ill-mated and unhappy marriages, reverses of fortune, or the failures and disappointments of life. "Life is big with shattered hopes and wrecked ambitions, and life is, therefore, full of wrecked and shattered nerves." The climacteric with its nerve disturbances, sterility and sexual excess, are each responsible for causing the disease. And when the general health is impaired, neurasthenia or hysteria are liable to fasten themselves upon sensitive or slightly diseased portions of the body, especially upon the reproductive organs, which hold an emotional kinship with the brain.

From the hyperemia and dysmenorrhea developed by the neuroses we may get secondary structural changes, such as hyperplasia, endometritis, and displacements, which need local treatment in addition to general measures, yet in many cases local treatment is not only unnecessary but positively injurious, and should not be resorted to. With young unmarried women we should not even make an examination of the uterine organs until after a thorough and exhaustive trial of general treatment for these conditions. The proper treatment for cases like the ones mentioned is that recommended by Prof. S. Weir Mitchell, with such variations as are indicated in each individual case.

Prof. Goodell says: "The crying medical error of the day is, in my opinion, the mistaking of nerve disease for womb disease."

405 Franklin Street.

No end of people suffer from bad food and do not know it. They do not get nourished. The food is often more than sufficient in quantity, but is very deficient in quality, and appears to be cooked by persons absolutely without sense. Cooking schools ought to be multiplied, and those who suffer in pretentious places from cold food which ought to be hot, and tasteless beef which ought to be good, should speak out, so that the steward and managers will remember that their customers are disgruntled, and never mean to come into the place again until things are changed.—*Post Graduate.*

SENILE GANGRENE.[1]

By HERMAN MYNTER, M. D.,
Buffalo, N. Y.
Professor of Operative and Clinical Surgery, Niagara University.

Senile gangrene is always caused by arterio-sclerosis. Senile marasmus, in the form of atheromatous degeneration, may occur in persons under forty years of age and be absent in octogenarians. I have myself seen a case of complete gangrene of one leg in a woman thirty-five years of age in which no other cause could be found.

Holmes states, too, that a person may be prematurely old from excess and suffer from gangrene at a comparatively early age. He mentions several cases, the youngest being twenty-three years.

An absolute vegetable diet is said to be followed by atheromatous degeneration of the arteries. (Holmes.) The same statement is made by Gubler, who believes that the calcareous degeneration of the arteries in pure vegetarians is due to the greater excess of earthy mineral salts in vegetables than in animal food. An exclusive diet of vegetables introduces an excess of these salts into the blood. Similar observations have been made by Raymond, who saw numerous cases of atheroma in a monastery of vegetarian friars. The prior, for instance, thirty-two years of age, had well-marked arterio-sclerosis.

Reports of many similar cases come from Bombay and Calcutta in people who live on an exclusive diet of rice.

A Dr. Alanus, who had lived for a long time as a vegetarian, made the discovery (published in the *Rhenish Courier*) that his arteries were becoming atheromatous, particularly noticeable in the temporal and radial arteries. He was below forty years of age, and could not account for it until he saw the connection between atheroma and a vegetable diet traced in a work by Monin, of Paris, in which Gubler is quoted. Dr. Alanus promptly returned to a mixed diet. In how far the frequent occurrence of atheromatous degenerations in diabetic patients may be traced to their preference for starchy, *i. e.*, vegetable food, future researches will show. It is a well-known fact that diabetic patients are apt to suffer from diffuse and localized inflammations and from gangrene, which is in no way different from senile gangrene. Examination for sugar ought never to be neglected in patients with gangrene, so much more is an antidiabetic diet apt to arrest the gangrene, if diabetes is present. I saw such a case a week ago, being called in consulta-

1. Read at the annual meeting of the Medical Society of Erie County, January 12, 1892.

tion to see a Catholic priest with a large inflammatory swelling in the middle of the back. The swelling was actually as large as a dinner-plate, and presented the common appearance of an enormous carbuncle. My first question was about diabetic symptoms. They had not been inquired into, but he suffered, nevertheless, from extreme thirst and frequent and copious urination. The urine had a specific gravity of 1030, and contained a great amount of sugar.

König found that sugar diminished in the urine after amputation for diabetes.

Israel, also, has pointed out the frequency of arterio-sclerosis in diabetes, finding it in thirteen out of twenty cases. As gangrene very rarely occurs in youthful patients with diabetes, the arterio-sclerosis is probably the main cause of the gangrene. The gangrene in diabetes may occur spontaneously or follow suppuration. König considers senile gangrene the result of an inflammatory stasis, which follows a slight injury, coldness and numbness having existed for some time previously. According to him, it is rarely the result of a marastic thrombus in the terminal vessels, producing localized mummification without previous inflammation, still more rarely the result of an embolus or of primary thrombosis of a large artery.

Heidenhain, on the other hand, who reports thirty cases of amputation from Küster's Clinic in the September number, 1891, of *Deut. Med. Wochensch.*, found by the examination of the amputated limbs, as a rule, an old thrombus in the femoral artery or in the anterior or posterior tibial artery. The thrombus was found particularly frequent in the popliteal artery.

Alcoholism is probably more or less a cause of gangrene on account of the fatty degeneration of the heart.

Moore gives as a primary cause, rigidity of the arteries and diminished blood supply on account of osseous deposits and diminished elasticity; as secondary cause slight injury under above circumstances, such as to corns, nails, particularly in cold weather.

Bryant gives as cause direct, arterial obstruction from atheroma or embolic plugging from breaking loose of some portion of the diseased arterial coat. Ergotism may, of course, produce gangrene from paralysis of the muscles in the vessels; so may we find gangrene on account of deficient nerve power in paralysis or in feeble, fatty heart, and if arterio-sclerosis be present as predisposing cause they may probably act as exciting causes. So

may slight contusions or wounds, as was the case in three cases of my own. If the supply of blood be insufficient, either on account of thrombus or embolus, we meet the dry gangrene with mummified appearance and lack of exudation. When the veins are obstructed, particularly on account of inflammation, we get copious exudation and moist gangrene. The rapidity of the extension in dry gangrene depends upon the condition of the bloodvessels. The gangrene may attack one toe or many or the whole leg, following one of the large arteries. Constitutional symptoms are absent and a line of demarcation will usually appear.

In moist gangrene, on the other hand, we have a copious exudation and infection with pus-microbes and putrefactive bacteria, which enter through the always present wound. Septicemia is always present, and a line of demarcation rarely forms.

In regard to symptoms, I refer particularly to Senn's Principles of Surgery.

The great *pain* and numbness preceding the gangrene, sometimes for weeks and due to the gradual ischemia, deserves mention, and these symptoms alone may put us on our guard.

Acute inflammation resulting in gangrene is attended with intense pain, which abates when gangrene occurs.

Tenderness to touch proves that gangrene yet is absent, just as absence of pain by puncture or incisions proves it present. The importance of this symptom is often overlooked. I was shortly ago called to a town some seventy-five miles from Buffalo, the dispatch stating an amputation necessary on account of blood-poisoning. I found a child, five years of age, who, eight days previously, had stepped on a nail. There was complete gangrene of the foot to above the ankle and enormous swelling of the whole leg, his femur being as large in circumference as my own from purulent edema, septic phlebitis and lymphangitis. The local doctor had treated the little sufferer antiphlogistically with calomel, physics and quinine, but had not thought of relieving the strangulation by incising the plantar fascia. Amputation was, of course, out of question. I made a great many long incisions to relieve the tension, but the patient died inside twelve hours.

The *pulse* may be felt above the thrombus, and furnishes the most important means of following the growth of an intravascular clot and determining its place.

The *swelling* is considerable in moist gangrene, and the slough is larger than the tissue it represents. In dry gangrene the parts

shrink and there is a diminution in size as compared with the normal condition.

Emphysema indicates the presence of different bacteria.

Color is first pale, then livid and of a lead-color, where the circulation has been arrested. The colored blood corpuscles undergo disintegration, the coloring material being diffused through the tissues and the interior of the bullæ. The black color is due to sulphuret of iron.

In dry gangrene we have no *odor*, in moist gangrene an offensive smell from putrefactive bacteria. Mummification can only take place where putrefaction is absent, a line of demarcation only in dry gangrene. Back of this line we have a hyperemic zone, due to collateral circulation.

The most important question is that of treatment. All authors agree in trying to prevent threatening gangrene by elevation of the limb and by heat; to prevent putrefaction by antiseptic measures; to prevent stasis by gentle rubbing towards the center and by avoiding everything which could produce stasis, by scrupulous care of abrasions, corns, bunions, etc.; to prevent marasmus by the judicious use of stimulants, tonics and a liberal diet; but when the question of primary amputation comes up we have any number of conflicting opinions, not alone in regard to the advisability of amputation *per se*, but also in regard to the point of election. Nevertheless, the opinions differ only in regard to dry gangrene, as Nature occasionally is able to overcome this unaided. In moist gangrene amputation is recognized as the only hope, and even here the successes have been few and far between.

Holmes says: "Let the surgeon beware of interfering with the separation of slough. Nature will accomplish this task best when unaided and surgical interference is, as a rule, dangerous."

Bryant: "As there is a depressed state of system, general strengthening measures as nutritious food stimulants and tonics are indicated. Amputation at line of demarcation when established."

Agnew: "Senile gangrene does not admit of operative interference. Surgeons are generally content to wait till line of demarcation is formed. There is only one justification for amputation, *i. e.*, line of demarcation, and the amputation must be done as near the ulcerating surface as possible."

Wyeth: "No operative proceeding justifiable until a well-defined line of demarcation is formed, unless septic absorption threatens life."

Moore: "Wait till Nature has arrested the progress of the disease, except in traumatic gangrene after crushing or after operations, which sometimes spread with great rapidity in uninjured parts. In such cases amputate high above the gangrene as it is useless to wait for line of demarcation."

Such opinions might be multiplied *ad infinitum* by consulting all the standard works on surgery in the English language. They all recommend to wait for the line of demarcation, as in that case there is established a compensating circulation and, at least, an attempt of granulation. In the periodical literature, on the other hand, we find numerous cases reported of early and successful cases of amputation in senile gangrene, sufficient to show that this wait-and-do-nothing policy is not adopted as the general rule in the profession. I do not at all deny that occasionally Nature can accomplish wonders, as, for instance, in the case of a patient on Niagara square, in Buffalo, whose leg, under homeopathic treatment, was allowed to amputate itself below the knee and really succeeded in doing so. Mr. Reginald Harrison (*Lancet*, November, 1884,) showed, at the Medical Society in London, a mummified foot and leg separated by spontaneous amputation. The patient was seventy-nine years of age and recovered. It is probably the best policy where only a toe or two are gangrenous and I have carried it out in one case in the General Hospital:

The patient was a man, sixty-one years of age, who had been healthy till three years previously when he lost all the toes and a part of the foot of left leg by senile gangrene, the process lasting fifteen months. The leg was thereafter amputated in middle third below the knee. Some sloughing occurred in the flaps but the wound healed. Six months later gangrene occurred of plantar side of right great toe, which came away in five months at the metatarso-phalangeal joint, and the wound healed. Then the second toe became gangrenous and sloughed away, then the fifth. On entering the hospital the fourth toe was black and mummified at second phalanx; pulse, 104; temperature, 98; no pain. The arteries in the wrist and femur felt like strings of beads. The toe was allowed to slough off and the stump healed.

Nevertheless, this is not the normal course by any means. In the great majority of cases the disease, as acknowledged by the standard authors, will terminate fatally in one to eight weeks, at least, before the line of demarcation has shown itself.

Watson Cheyne advocates, from theoretical reasons just mentioned, early amputation.

Mr. Harrison Cripps (*British Medical Journal* of May, 1885,) reports a case from St. Bartholomew's Hospital, in which he amputated in the lower third of crus. The patient was sixty-five years, diabetic and a drunkard, with slowly progressing gangrene, which had attacked the whole foot. The wound healed without accident.

James Cantlie (*British Medical Journal* of October, 1886,) had a case of recovery in a lady eighty-two years of age, beginning in the great toe. Teale's amputation above the ankle was performed and the wound healed perfectly.

Mr. Keall, of Bristol, (*Lancet*, 1884,) reports a case in a man in which he made a partial amputation, first removing two gangrenous toes and heads of metatarsals from right leg, there being no line of demarcation and the incisions passing through the red, inflamed and edematous integuments of the dorsum of the foot. Eleven months later a Forbes' amputation was performed on left foot. He advocates early operation through moderately healthy tissue.

Hutchinson is the first one who strongly recommends, in all cases of senile gangrene, to amputate the femur in the lower third. In amputation below the knee relapse will occur according to his statement.

König warns against being too ready to operate in diabetic and senile gangrene, unless septicemia is present.

In diabetic gangrene the prognosis has always been considered particularly bad.

Mayer mentions eleven amputations, of which six died and the gangrene returned in the five left. Of sixty-one not operated cases eighty per cent. died.

In *Deutsche Med. Wochenschrift*, of September, 1891, I find a lengthy and very important contribution to the subject by Heidenhain, who reports thirty cases of amputation from Küster's Clinic in twenty-five patients, three patients having double amputations, and one triple amputation. Eleven had diabetes and fourteen pure arterio-sclerosis. Besides these thirty amputations ten secondary amputations were performed on the same patients on account of return of gangrene.

Küster made first low amputations but got relapse every time, and then amputated high up and became, therefore, gradually convinced of the necessity of making high amputations as soon as the gangrene had reached the dorsum or planta of the foot. Of

thirteen primary amputations below the knee (including Chopart's and Lisfranc's amputations) only two amputations of the crus healed, two died of gangrene of flaps, and nine were reamputated above the knee. The result of high amputations was much more favorable. Of *eight* primary low femur amputations through the condyles, two died of diabetic coma and six recovered, but in two cases reamputations higher up became necessary on account of gangrene of the flaps. Thirteen supra-condylic amputations (six primary and seven secondary, for recurrent gangrene) are mentioned.

Four died of the *six* primary amputations (one of gangrene of flaps and hypostatic pneumonia, one of marasmus, one of diabetic coma, and one (fifty-eight days later) of recurrent gangrene). Two recovered, but in both gangrene recurred, and one was reamputated in the middle of the femur.

Of the *seven* secondary amputations two healed by first intention, three after slight marginal gangrene, and two after extensive flap gangrene.

To recapitulate, of *seventeen* primary amputations through or above the knee nine recovered and eight died of diabetic coma and heart complications, but of the nine only two healed by first intention, three after marginal gangrene, one after extensive gangrene and three after amputations higher up.

Of the ten secondary femur amputations all recovered, three by first intention, six after marginal gangrene and one after reamputation. *Eleven* of the twenty-five patients had *diabetic gangrene*, of which six recovered by a high amputation and five died, four of coma and one of heart disease. Fourteen had pure senile gangrene, of which nine recovered and five died, two of recurrent gangrene following a Lisfranc amputation and a low crus amputation, two old people (seventy-eight and eighty years old) of hypostatic pneumonia, and one patient of myocarditis and nephritis. All patients recovered by high amputations who did not suffer from diabetes, albuminuria or heart troubles. It is of interest to note that low amputation generally terminated in gangrene. Heidenhain explains this by the usual fund of a thrombus in the femoral or popletial arteries.

I have, in the last few years, had occasion to amputate three times for senile gangrene. Two died, a low crus amputation and a low femur amputation, both from recurrent gangrene, while one recovered from a high femur amputation although very much debilitated at the time.

Case I. was that of a man sixty-three years of age, a grocer and moderate drinker. I was called in consultation by the late Dr. Meisburger and heard the following history:

The patient stepped on a nail three weeks previously and an inflammation beneath the plantar fascia resulted. Some small incisions had been made, but there was diffuse moist gangrene without line of demarcation, extending till above malleolus internus.

Amputation of crus in lower third. The arteries were found as stiff as leadpencils, and were ligated some inches higher up. The gangrene recurred promptly. Reamputation was declined and he died on the seventh day.

I then made up my mind, in a similar case, to amputate higher up.

Case II. A man, sixty-three years of age; rich brewer; hard drinker. I was called in consultation by Dr. Cott. Had for two months intolerable pain in the right big toe, which was livid and had a gangrenous spot as large as a ten-cent piece, opening into the metatarso-phalangeal joint. He ascribed the condition to a bad corn, which a barber had cauterized with caustic potash. I did not suspect senile gangrene and, therefore, amputated the toe and the head of the metatarsal bone. Next day gangrene of the dorsum appeared, reaching on the second day to the malleolus internus. Third day, amputation in lower third of femur, but even here the arteries were moderately sclerotic. Gangrene recurred and he died on the ninth day.

Case III. A man, sixty-four years of age; moderate drinker. He had a slight injury two months previously, followed by inflammation and gangrene, intolerable pain and great weakness. The gangrene extended up along the inner side of the foot to the internal malleolus; no line of demarcation. Amputation in upper part of crus, but, as the arteries were found full of chalky material, amputation in the middle part of femur was made.

He made a good recovery. The wound healed by first intention, except on one spot over the inner part, where a little hardness was felt which increased in size and at last protruded as a bleeding mass through the skin, as large as a goose-egg, and resembling a fungus hematodes. The wound was re-opened and the tumor found to be an aneurism of the end of the femoral artery. It was extirpated, the artery ligated again and the wound healed promptly.

After this experience, and comparing it with the statistics of Heidenhain and others, I think I am justified in all cases of severe senile gangrene, which takes in more than a toe or two, in recommending immediate amputation in the middle, or rather above the middle, of the femur, and in discouraging all attempts of saving

parts of limbs by low amputations, of waiting for a line of demarcation and in a general way of doing nothing, trusting to nature to do what it, in the great majority of cases, will not do.

195 FRANKLIN STREET.

THE FARADIC COIL IN GYNECOLOGICAL PRACTICE.

BY HERMAN E. HAYD, M. D., M. R. C. S. (Eng.), BUFFALO, N. Y.

IN THE August number of the *Post Graduate* there appeared a paper by Dr. Bache Emmet, as well as the discussion by many of the most prominent gynecologists in New York City, which serves to show the interest the profession is taking in electro-therapeutics. It is but a few years ago, and certainly within the recollection of most of you, that these same men looked with surprise and even contempt upon those reputable and scientific men who were wasting so much time and energy over that so-called dangerous plaything. And yet, as Emmet says, there is hardly a gynecologist in New York City, or in any city in the United States, who is not using this valuable agent in his every-day routine work with benefit and satisfaction in properly selected cases.

The possibilities of the galvanic current are no doubt familiar to you, since so much has been written upon it during the past few years; but the literature, as well as the conclusions in reference to the special uses of the faradic, are still unsettled. To Apostoli is due the credit of not only giving the galvanic current its scientific importance, and its wide application in special forms of disease, but he has also, by much labor and experiment, developed the properties and uses of the faradic. He found that the more the wire of the secondary coil was attenuated, the more sedative were the properties of the current generated, consequently he was led to use it in the treatment of acute and subacute inflammation of the uterus and its appendages. Unfortunately there is no guide or standard in the manufacture of faradic batteries, and in order to get actual and uniform results from relatively different sized wires, the construction of the battery must have your special study and consideration. Engelmann's coils are, on the whole, very satisfactory. His number one coil is made of number sixteen wire, and seventy-five yards in length; (2) twenty-two wire, 225 yards in length; (3) number thirty-two wire, 660 yards in length, Brown & Sharpe American scale. You will find in most batteries, and particularly the cheaper ones, coarse wire from fifteen to thirty, and about

1. Read to the Buffalo Medical and Surgical Association, January 5, 1891.

sixty feet to 200 yards in length; the principal motive on the part of the manufacturer being to give a loud, noisy, powerful machine. This brings us to a second consideration, namely, the vibrator, which should be easy and simple in adjustment, and capable of making very fine and very rapid vibrations. When the coarse wire is employed, it is with the expectation of giving tone and strong muscle contractility; therefore the vibrator should be slow, so as to make the muscle alternately contract and relax itself; but when the fine wire is used, it is with the expectation of relieving pain, and producing sedation in excitable nerve areas and irritable muscle-contractions. When the interruptions are rapid, the muscles are unable to respond to every vibration, and a constant contraction or a tetanoid condition is produced, which eventually wears out this contractile power. The same constant and intense stimulation of the sensory nerves results in a temporary loss in their power to respond; and, as a consequence, a condition of anesthesia is produced, more or less prolonged, depending upon the duration and frequency of the applications. With the "Goelet" coarse wire, the vibrations should be from fifty to eighty per second, while with the fine wire they should be from 150 to 200 per second.

I have been especially pleased with the faradic coarse coil, or coil of quantity, in recent subinvolution following abortion, when slight hemorrhage continues for days, and even weeks, due to a want of tonic contractility in the uterine muscle-fibre. Ergot and other uterine stimulants are often insufficient to control this condition, and there soon results, from a simple inertia, a possible chronic subinvolution, with fungous endometritis, salpingitis, and all their attending complications. Moreover, after too frequent child-bearing, or in conditions of debility accompanying recent parturition, when the womb lacks its proper contractile power, and, as a result, absorption and involution are impeded, the faradic current, combined with general tonic treatment, will often afford the most satisfactory results. These treatments can be taken by the patient herself, and require simply a clay abdominal pad and a vaginal electrode, and as much electricity, gradually turned on, as the patient can bear. The séance should last about ten minutes, two or three times a week. Cases of this kind I reported in the December 19th number of the *New York Medical Record*, in a paper on the Treatment of Uterine Hemorrhage. You will also find that these cases are often complicated with vaginal subinvolution when the canal remains large and its muscular walls are relaxed and

flabby, a condition in which you would expect, and, in fact, will surely find benefit from the application of the coarse faradic coil with slow interruptions. Moreover, all cases of simple pelvic congestion, when the hemorrhoidal vessels, and the pampiniform plexus of vessels in the broad ligament are over distended, and when there is more or less sagging or dropping down of the whole pelvic contents, with settling down of the bowel itself, and, perhaps, constipation, with a relaxed perineum, are often quickly relieved by this form of electricity.

But the fine coil, or coil of tension, is what I wish particularly to draw your attention to, because it possesses such powerful sedative properties, which can be utilized for the relief of pain, which is the most prominent symptom in connection with so many forms of womb trouble, an irritable or hyperesthetic nervous supply, or from more or less acute inflammatory exudates in the womb itself, or its adjacent tissues. I have reported in the *Archives of Pediatrics, Obstetrics and Gynecology*, September, 1891, some interesting cases, where the results were very gratifying. You will find it especially valuable in those acutely retroflexed wombs where the body is so hypersensitive that even the slightest pressure upon the mass gives excruciating pain, and where the vaginal walls themselves are tender to the touch; in inflamed, tender, and often prolapsed ovaries, accompanied with much pain in the iliac fossa, pain and sickness in the pit of the stomach; also in some neuroses, vaginismus when an operation is not called for, and certain irritable conditions of the nervous mechanism of the bowels, where flatulence, roaring, or croaking noises seriously disturb the comfort and happiness of some women. In one case, that of a young, unmarried woman, in whom I had tried every medicine known to me without effect, and where the condition was so exaggerated that she was denied the pleasure of society, and was becoming a hopeless hypochondriac, I found both ovaries tender and sensitive to the touch, with marked vaginismus, and, after a few treatments, ten in all I think, together with a good tonic course of medicine, which had been given the patient for some weeks previous, a perfect cure was effected.

It is, moreover, a valuable agent to commence the treatment of painful conditions; in fact, to supplement galvanism, vaginal or intrauterine, when indicated.

It has one great advantage in being practically without danger, unless carelessly administered in acute inflammations, since intra

uterine manipulation is uncalled for, unless under very special circumstances, when it may be found advisable to use it intra-uterine. Care should always be exercised to commence a painful case with a very fine wire and a long coil; have a clean, easily adjusted, rapid vibrator; commence with the weakest possible current, and gradually, without shock or interruption, increase it, and reduce it with the same care, and continue the treatment for fifteen minutes, when you will often find complete anesthesia of a previously painful, highly sensitive mass.

Let me report an interesting case, not previously recorded, since it is a young woman who has been under the care of many of you, and who finally saw nothing before her but laparatomy for the possible relief of her suffering. I also show for your inspection ten different pessaries worn by this young woman, which demonstrates conclusively how uncalled for pessaries are in many cases so frequently treated by them. In fact, I am of the opinion that not one in ten pessaries that are employed nowadays in the average general practitioner's practice can do anything but harm.

S. D., *æt.* twenty-eight: unmarried; well nourished; brunette. Menses first appeared when twelve years of age, with great pain; regular for some years, and periods lasted three days; flow never profuse, and came every twenty-eight days. She consulted me on April 4, 1891, complaining of great pain when unwell, in fact, so violent that she could not lie down in bed, but would roll and writhe in agony, and scream from the violence of her suffering for at least twenty-four hours if morphine were not administered; constant and protracted retching, and often vomiting of blood. Bloating, and violent pains in the breasts. For the last three years periods have come every twenty to twenty-three days, and during the whole crisis she would see but a few drops of blood. During the interval she complained of having dorsal pain, pains in the groins, and excessive backache, with constant desire to stool, as well as frequency and precipitancy in urination; extremely nervous and hysterical, suffering much from globus and throat constriction; in fact, a physical wreck. Locomotion painful, and she would never attempt to walk more than a few squares. She stooped to the left side, and the dresses were always first worn out on the left side. No pain on urination, but great distress after the act; nocturnal desire, and she would be compelled to get up three or four times a night. Some discharge; bowels costive.

Diagnosis: Acute retroflexion with considerable fixation; enlargement. Some thickening in both ligaments, especially the left, where the ovary could be felt extremely tender and enlarged. General congestion of cervix; endocervicitis; endometritis; *hysteria.*

The examination caused considerable pain, but not from acute inflammatory exudate, but a general hyperesthetic condition of the parts. The patient was given a treatment with the fine faradic coil, number thirty-two, 2,884 feet long, for fifteen minutes with the effect of materially lessening the pain immediately upon examination. Six Léclanche cells were used. The vagina was tamponned with a ten per cent. solution of ichthyol in glycerine, and a mixture given of tinc. valer. ammon., M. xv., sp. ether chlor. M. v., every fourth hour. The treatments were continued every other day, with the effect of gradually overcoming all the pain and tenderness upon examination. Then Goelet's clay-ball electrode, positive galvanism fifty ma., for seven minutes was applied three times a week to the retroflexed mass and vaginal vault, and finally the negative pole, with the expectation that it would more speedily dissipate the exudate, and possibly lessen the adhesions. After each treatment the tampons were again applied well behind the os. Up to May 25d it was with difficulty that I persuaded the patient of the improvement in her local condition since her general symptoms were those of discomfort and suffering; but on June 15th she reported: Menses came on the twenty-fifth day, the first time in three years at such a long interval, with some pain but didn't take to bed; was feeling very well; her despondency and unnatural forebodings were passing away; was in good spirits; walked from North street without pain, and for the past two days didn't know what pain was, while heretofore never knew what it was to be free from it. The treatments were continued twice a week for two months longer, when the patient felt comfortable enough to remain away, which she has done for the past three months; reporting after each period. Upon the last examination, October 25th, the womb was found to be free from pain upon extreme manipulation, the flexion was much improved, in fact, the body was simply directed posteriorly, and her general condition was satisfactory. Some adhesions still existed, but no tenderness.

Now, what constitutes a cure? Must the womb be anatomically in a certain angle, or in a definite line, which shall run from the umbilicus to the base of the spine? No; but the acute and subacute congestion, as well as inflammation and the inflammatory adhesions, which caused so much pain and tenderness, and irritative disturbance, must, to a very great extent, disappear; then, nature will tolerate, as she usually does, a slightly misplaced womb, when this malposition is not accompanied by irritable parametritic deposits. Moreover, by desisting from needless intrauterine medication, the introduction of unnecessary foreign bodies in the shape of electrodes, sounds, stem pessaries and ordinary pessaries, which were uncalled for, at all events in her case, no irritative phenomena

resulted from the applications; and, as a result, there was uterine sedation and physiological rest, affording the best possible means for the absorption of the inflammatory products. The periods were associated with but a moderate degree of pain, and were somewhat increased in amount, and the vesical disturbance, as well as the general reflex irritative symptoms of the stomach and other organs, disappeared. Normal and equable discharges of nerve force took place, and instead of a broken-down, shattered, and hysterical nervous system, brought about by constant ovarian irritation, one of healthy and settled function resulted. The patient is in good health and spirits, increased in flesh, and to all intent and purpose a well woman.

78 NIAGARA STREET.

A RETROSPECT OF MEDICAL PROGRESS, IN THE STATE OF NEW YORK AND THE COUNTY OF ERIE.[1]

BY E. C. W. O'BRIEN, M. D., Buffalo, N. Y.

ON SUCH an occasion as this it will, I think, not be profitless, if, acting as your representative and speaking in the capacity with which your kindness has invested me, I take a cursory survey of what is going on in our profession at large; and, then, a closer view of what we are doing in our own country, our own State, and our own county. Often as the mirror of medical progress has been appealed to, it is pleasant to take another look. If you compare the medicine and surgery of the present time with the medicine and surgery of even so recent a time as twenty-five years ago, we find on the one hand that method has succeeded to guess-work, and, on the other hand, that the boldness of security has taken the place of the timidity and inaction that are inseparable from ignorance.

In medicine, it is undoubtedly to the study of microörganisms, and their relations to disease—in other words, medical bacteriology—that the advance which everybody recognizes, is largely to be credited. This study, to be sure, has still to be pursued to an extent compared with which its present state is embryonic—perhaps, hardly more than germinal—and by this I mean, not that what we most need is the discovery, and establishment of the

1. Annual address of the President of the Medical Society of the County of Erie, delivered January 12, 1892.

pathogenic relations of more and more microbes, although this, of course, is desirable and sure to be accomplished, but that we have still to learn many times as much as we know, or can reasonably conjecture, at present, as to the ins and outs of the part played by familiar microbes with regard to pathological processes.

But on this subject I need not enlarge ; our current literature is full of it. Merely one phase of it — that of the bacteriology of septic and purulent processes — has proved the master factor in the immense strides made by surgery during the closing third of the century. The old surgery had gone about as far as it could go ; improvement in technique hardly heightened its efficiency in saving life and limb ; something radically new, pervading it through out, and changing it interstitially, was needed for its regeneration. And that thing came in the form of antisepticism — Listerism, for such it is only right to call it as a trifling tribute to Sir Joseph Lister's great services to surgery and to mankind.

We see their beneficence not only in the better showing made in surgical practice, but also in the impetus to bacteriological study, in its application to general medicine, that might otherwise have required many years for its initiation. To this impetus we owe it that every well-appointed medical college now has its bacteriological laboratory. It is true that the course of bacteriology is not an uninterrupted march of attainment. This is shown in the present status of the Koch treatment of tubercular disease. Hardly more than a year has elapsed since what was announced as a triumph of the first magnitude came to us from the very vital knot of bacteriology ; today it seems little better than a fiasco. Great as our disappointment is, is there not a wholesome lesson to be drawn from the fate of Koch's lymph ? Should we not infer that closest research ought always to be checked by experience in real life ; and would not such an inference lead to greater safeguards against loss of time and misdirection of energy in our quest after the secrets of nature ? If we must own to defeat for the time being, surely our forces are not routed. Who doubts that tubercular disease, cancer, leprosy, and the acute infectious diseases will, before many years have passed, be made as tractable as those we now encounter with every expectation of victory, although our forefathers were powerless against them ?

Preventive medicine, sanitation, hygiene — call it by whatever name you will — is walking hand in hand with bacteriology ; and the two are at many points so blended as to be almost identical.

Disastrous epidemics there are still, no doubt, but none of the terrible destructiveness so common a century or two ago. This is because we do not now content ourselves with simply referring to an epidemic pestilence as being a "dispensation of Providence;" but seek by all possible means to find out the cause of infectious disease, and the methods of rendering those causes inoperative. We are constantly trying to get the mastery of pestilential diseases as Jenner mastered smallpox a little less than a century ago. That we shall succeed in time there is abundant reason to believe. I might mention many other achievements in medical science, either completed or in course of completion, that have aided powerfully in securing an evener distribution of human happiness than was possible in former times; but I will content myself with one -that of establishing the conviction in all civilized communities that insanity is not demoniacal possession, but the expression of disease.

Ever since Esquirol's time has it taken to do this; but it has been done. The insane are now the subjects of the utmost consideration, the tenderest solicitude, and the most painstaking care on the part of the individual and the state. Palatial hospitals and kindness have taken the place of the wretched abodes and the gross ill-treatment too often given them, even in comparatively recent times. We do not now punish the criminal insane—meaning those who commit acts that in others would be criminal; we confine them, to be sure, in their own interest and for the welfare of the community; but we manage them almost without even "chemical restraint." And I am glad to be able to truly allege that our own great State of New York is not surpassed by any State in the Union in thoughtful and generous treatment of the insane. I have thus mentioned a few of the more striking of the manifestations of progress in the pursuit of medicine.

To what extent have we in this part of the world—in this country, in the State of New York, and even in the County of Erie—contributed? Not to an overwhelming extent, it is true; still, bearing in mind the disadvantages under which we have labored, we need not feel that we have been backward in taking our part in the good work. It was in the United States that surgical anesthesia was first accomplished; that ovariotomy was first performed; and that litholapaxy was made to supplant lithotomy and lithotroty to a great degree. It was in the State of New York that chloroform was first discovered, that the elastic extension in treatment of fractures was first applied; and that college clinics were first

held by Willard Parker. In New York, Bull has made many successful laparatomies for gunshot injuries of the intestines. In New York, Marion Sims, the epoch-making gynecologist, founded the first hospital devoted to the treatment of diseases and injuries peculiar to women. In New York, Sayre added greatly to our knowledge of the proper treatment of spinal curvature, and he has given us many new and valuable ideas in orthopedic surgery. In New York, Wood made known the powers of nature in the regeneration of bone. In New York, Clark taught and practised the opium treatment of peritonitis, though his extreme views have been antagonized by modern investigators. In New York, Stearns did invaluable work when he established confidence in the oxytocic power of ergot in the early days of its use. In New York, Otis revolutionized the diagnosis and treatment of urethral stricture. In New York, O'Dwyer perfected intubation of the larynx, and made it practicable.

These are but some of the striking achievements in medicine and surgery, that have happened in our own State. When we add to this list the familiar names of Thomas, Emmet, Barker, Taylor, Post, Sands, Carnochan, and many others whose achievements in their special fields of work have given them world wide reputation, we have a list of names at once an honor to medical science and to America. As for our own County of Erie and our own City of Buffalo, we can fairly claim that our profession has kept well to the front. The County of Erie and the City of Buffalo gave to the medical world that illustrious trio, Flint, Hamilton and Dalton, the foundation of whose experience and fame was laid here. It was Erie County and Buffalo that furnished them the clinical material from which they obtained the knowledge out of which grew those published works which are looked upon as standard authorities in all lands. A little later the leading minds of our profession here were White, Rochester, Miner, Moore, (of Rochester, N. Y.,) Hadley, Lee, Eastman, Milton G. Potter, and the late lamented Burwell and Frank H. Potter; besides, others who could be named if time permitted. At the present time we have in our city many distinguished medical men, some of them of national repute. Prominent among these is Roswell Park, the first in this State to localize and operate successfully upon a cortical lesion of the brain, ante-dating Horsley in this field by about three months. To him also is due the credit of having been the first in America to successfully extirpate the larynx. His fame as a pathologist led

the College of Physicians and Surgeons, of Philadelphia, to invite him to deliver the Mütter lectures for 1890-91, he being the first non-resident of Philadelphia to whom this great compliment has been extended. Another name is that of M. D. Mann, whose operative skill, together with his System of American Gynecology, a book which is considered one of the finest in the English language, entitles him to high rank among American gynecologists. Again, Herman Mynter, a successful teacher and practitioner of surgery, who has won credit for himself and his city through his surgical skill, as evidenced, for example, by his excellent record in his operations for the relief of perityphlitis. I feel that I should mention John Parmenter, who has done considerable and creditable work in the surgical field, and who recently and successfully performed the rare operation of open arthrotomy for subclavicular dislocation of the humerus,—the fourth operation of its kind that has been done in this country. Stockton, also, through the more extended use of gastric lavage, has done much towards changing our ideas of the therapy of stomach difficulties. And so I might go on, did time and space permit, with mention of men of recognized ability as teachers, and who are frequent and valued contributors to medical literature. Such for instance are W. W. Potter, J. B. Andrews, Cronyn, Lothrop, Howe, Abbott, Hopkins, Hubbell, Bartlett, Putnam, John Parmenter, W. C. Krauss, Hartwig, Pryor, Crego, John A. Miller, Cary, Wende, Fell, DeLancey Rochester, Hurd, Hayd and Grove.

Nor is our city lacking in opportunities for clinical study. In addition to the large and excellent corps of teachers connected with our two medical universities (both of them institutions of excellent reputation), we have three large general hospitals, namely : the Buffalo General Hospital, the Sisters' of Charity Hospital, and the Erie County Hospital, the combined capacity of these being about seven hundred beds. To these we may add the Fitch Accident Hospital and the Emergency Hospital, the ambulance service in both of which is unexcelled ; and to these we may add, again, several well-appointed and well-conducted dispensaries, representing the various special departments of medicine. The insane are well cared for in this city by the large and well-equipped State Hospital, and by the Providence Retreat, on Main Street, near Highland Park. The latter is conducted under the management of the Sisters of Charity, is delightfully located, and with its admirable staff of physicians, is one of the finest private hospitals

for the insane in this State. Therefore, the student who seeks to obtain his medical education in Buffalo will most assuredly find that the opportunities afforded him will in every respect, be as good as those furnished by any city in the United States.

Retrospects of this kind are cheering; but, let us not copy the *gens d'armes* in the opera, who lose time in melodious self-congratulations while the fugitive, of whom they are in pursuit, diligently widens the distance between them and himself. It rests with us to press on constantly; only stopping to take in the situation, so to speak, to make sure that we are not on a false scent.

That in this honorable contest, the medical men of the County of Erie, the members of this Society, will always stand well for ward in the ranks, I firmly believe; and you all believe it, for I am sure that you have resolved that it shall be so.

Society Proceedings.

From The American Journal of Obstetrics

TRANSACTIONS OF THE FOURTH ANNUAL MEETING OF THE AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS.

HELD IN NEW YORK CITY, SEPTEMBER 17, 18, AND 19, 1891, AT THE ACADEMY OF MEDICINE.

(*Abstract.*)

Third Day—Morning Session.

The President, Dr. A. H. Wright, of Toronto, in the chair.

Discussion of papers by Dr. Wathen and Dr. Marcy, resumed.

Dr. W. W. Potter, of Buffalo, said he had kept watch of Dr. Marcy's work in this direction, and had become somewhat familiar with his writings on the subject. His little treatise, upon hernia, published two years ago, was a revelation to many with reference to the modern technique of the operations for the several forms of hernia. Dr. Potter reported a case of ventral hernia upon which he had operated fourteen years ago with success.

Dr. R. B. Hall, of Cincinnati, said he hoped that Dr. Marcy, in closing, would give in detail the method of closing the abdominal wound after operating for hernia—whether he advises and uses the kangaroo tendon in closing the peritoneum. He had operated a number of times, using catgut, and was disappointed in its results.

Dr. J. H. Carstens, of Detroit, illustrated on the board the old-fashioned method of including all the tissues in one sweep, resulting frequently in hernia, because too much of the peritoneum was included in the tissues taken up. He said that if you will take catgut or kangaroo tendon, or whatever you like, and sew, layer by layer, up to the skin, you will get perfect union; you get peritoneum together, you get fascia together, and you get no umbilical hernia. If you follow in the track of Lawson Tait, you will be astonished at the number of cases of umbilical hernia you will find; and if Mr. Tait would advance to the American plan, and accept a little from us, and make use of the buried animal suture, he would very seldom have a case of hernia following an operation.

Dr. R. T. Morris, of New York, wished to lay emphasis upon the danger of peritoneal hernia where the operation was performed with one suture, not bringing the different layers together successively.

Dr. Jas. F. W. Ross, of Toronto, said he regretted that we were not able at the present moment to decide the question between the method of taking peritoneum, skin and fascia together, and the other method of suturing each separately. He had always adopted the single suture, taking up all the tissues, and up to the present time had only two cases of hernia. He wished to ask Dr. Marcy whether it had been experimentally proved that fibrous tissue unites to fibrous tissue, and can be traced absolutely as fibre in the scar; whether muscle unites to muscle, and can be traced as muscular tissue in the scar. On the surface, where we can see, we find it is not true skin in the scar.

Dr. H. O. Marcy, closing the discussion, said he wished to speak more particularly in reference to the subject presented by Dr. Wathen. Dr. Wathen's excellent results showed him to be a very careful operator, but there were some points in which he did not agree with his method of operating. It is some twenty years since, as a pupil of Mr. Lister, Dr. Marcy first began the study of wound treatment. During this time he had carried on many care-

ful bacteriological experiments in his own laboratory. He thought it would not be quite right to accept Dr. Wathen's conclusion that it is no longer antiseptic surgery, but aseptic surgery, although the aseptic wound is our highest ideal and is that to which we strive to bring the result.

We place far too much emphasis on what we call the atmospheric conditions, and far too little on a dirty finger nail. He was not prepared to feel that he could afford to dispense with irrigation. Another point was, not to fill the wound with a dozen or twenty compression forceps, and then expect union by first intention.

In his last hundred laparatomies he had turned on an aseptic gas—oxygen gas—the moment he entered the abdominal cavity. It is a non-irritating gas, and displaces the column of infected air that would otherwise gain access to the wound.

Septic wounds are to be treated in one way, aseptic wounds in another; the latter should never have a drainage-tube applied. He uses a far less number of drainage-tubes than formerly, and insists upon it that the drainage-tubes shall be smaller, shorter, and less in number.

In reference to sutures, silk is encysted; it is not absorbed. He had removed it after it had been in place three years. Silkworm gut is equivalent to wire. At the best the tissues encapsulate it; they do not utilize it by absorption or a replacement of other tissues. For many years he was satisfied with catgut; he prepared his own; but he was brought to feel that catgut was not reliable—may not be reliable. The best tendons which he had been able to find were those taken from the tail of the Australian kangaroo, after experimenting with tendons from the deer, moose, squirrel, caribou, buffalo and other animals.

He illustrated on the board the anatomical conditions pertaining to umbilical hernia.

Dr. X. O. Werder, of Pittsburg, Pa., reported cases illustrating

SOME MOOT POINTS IN ECTOPIC GESTATION.

On the 23d of May last he operated on a patient, thirty-eight years of age, mother of five children, in whom the menses had been regular up to six weeks previous to operation, during which time there had been a constant flow of blood. A mass in Douglas's cul-de-sac had been made out, pushing the uterus to left of median

line, soft, semi-fluctuating, of the size of a large orange. After intestines and omentum which were adherent to this mass had been separated, a blood tumor was found, and several handfuls of blood coagula having been emptied out of the abdominal cavity, the ruptured, dilated right tube, containing a placenta, was brought up into the abdominal incision and ligated. The abdominal cavity had been perfectly free from blood previous to breaking into this mass, and there were no signs of any inflammatory trouble. There was no doubt that this tumor was a pelvic hematocele, caused by tubal pregnancy rupturing into the abdominal cavity. Rupture had undoubtedly occurred, as the history shows, about six weeks previous to operation.

This case illustrates, contrary to the teachings of Tait and others, that not all cases of intraperitoneal ruptures of tubal pregnancy prove fatal.

Two other cases seen by the author, of undoubted ruptured tubal pregnancy into the abdominal cavity, in which operation, urged as the only hope of recovery, was refused, also recovered, though convalescence was slow and tedious; in fact, the patients, though months have elapsed since occurrence of this intraperitoneal hemorrhage, are still more or less invalids.

In two other cases laparatomy was not performed until five days after rupture had taken place, when the patients were recovering from their condition of collapse and apparently improving. Out of a total of six cases of tubal pregnancy, therefore, in five recovery would have been probable without operation.

The author therefore concludes:

1. Intraperitoneal rupture is not always fatal; a large percentage recover without operation.

2. The convalescence of those recovering without operation, in his experience, is very slow and tedious, and often, perhaps, impossible without subsequent operation.

3. Laparatomy is to be recommended not only in cases before rupture, and after rupture for the purpose of stopping hemorrhage which threatens life, but also after bleeding has ceased, and even if hematocele has formed, because by it we remove all present and future danger, and insure our patient a very rapid and uninterrupted convalescence. Laparatomy has proven to be, if performed by skilful hands and with all necessary precautions, a perfectly safe operation.

The remaining tube should not be removed—*i. e.*, the tube not

the seat of fetation—as has been recommended by some to prevent a recurrence of pregnancy in that tube, unless it is markedly diseased. Removal of it became necessary only once in the four cases operated on for ectopic gestation by him. Two cases subsequently became pregnant, one has been delivered of two living children, and another is now in her seventh month of pregnancy.

Dr. Florian Krug, of New York, gave a short historical sketch of the employment of

TRENDELENBURG'S POSTURE IN GYNECOLOGY.

Dr. Krug witnessed a suprapubic cystotomy done in this position by Dr. Willy Meyer, formerly Prof. Trendelenburg's assistant. He was immediately impressed with the great advantages this method offered for abdominal work, and at once set out to make use of it. He has since done over one hundred and fifty laparatomies in this posture, and has induced a great many operators on this side of the Atlantic to adopt it.

Dr. Krug claimed the following advantages for the method: If the patient's pelvis is raised up so that the symphysis forms the highest point and the body comes on an incline of at least 45° to the horizontal, all the viscera of the abdominal cavity will gravitate toward the diaphragm and the pelvis become free and easy of access. The small intestines will hardly come into view and never trouble the operator during the operation. The operator is enabled to see everything that he is doing and need not grope around in the dark. All bleeding points are readily detected and tied. In weak and anemic patients the posture is a great advantage, preventing shock from acute anemia of the brain. In all his operations he had never found any objectionable point or disadvantage in this posture. There are different ways of putting the patient in this position, very simple and very complicated ones. In most of his operations he had used the head-rest of an operating table, to which cushions were fastened with straps. Trendelenburg himself has had a very complicated operating chair constructed, which answers all requirements. Several new devices have been brought out in New York lately.

Dr. Krug had lately constructed a frame of galvanized iron, which can be screwed to any laundry or operating table. The upper part of this frame is covered with sailing canvas, a material which is durable, easily sterilized, and cheap. Straps are provided for the knees and ankles of the patient, whose pelvis can, by a

simple mechanical arrangement, be elevated to an angle of 45° to 60°, and lowered again if required. The frame can easily be carried or taken along in a street car, and can be used on any kind of a table: it is easily cleaned and sterilized, and it is cheap.

Dr. R. T. Morris, of New York, said that those who had once seen an operation in this position would appreciate fully the great value of Trendelenburg's invention.

Dr. H. O. Marcy, of Boston, presented photographs showing a modification of the Trendelenburg chair.

Dr. J. H. Carstens, of Detroit, spoke of the danger of atmospheric infection from the air rushing into the abdominal cavity, as had been stated was the case as soon as the abdominal walls were opened. He considered that that would be a decided objection to the Trendelenburg position.

Dr. Willy Meyer, of New York, replied to Dr. Carstens's objection that the danger from atmospheric infection would be very slight, certainly no greater than in amputations and similar open work, in which cases he always expected union by first intention. He then gave a demonstration of the Trendelenburg posture on a table after Trendelenburg's original model that he had imported.

Dr. Krug, in closing the discussion, said that ever since he had used the Trendelenburg posture he wondered how he ever got along before. He considered that it would be a very fine distinction between the amount of air which entered the abdominal cavity in this posture and that which enters in ordinary operations. He had used the operation in from one hundred and fifty to two hundred laparatomies, and was willing to match his results with those of anybody else who operates in a horizontal position.

Dr. Rufus B. Hall, of Cincinnati, read an essay upon

SUPPURATING CYSTS DEVELOPED FROM ADHERENT OVARIES AFTER REPEATED ATTACKS OF INFLAMMATION; AND SECONDARY OPERATIONS FOR REMOVAL OF DOUBLE INTRA-LIGAMENTOUS CYSTS.

His conclusions were to the effect that, if these cases were operated upon early, just as soon as the physician was certain that nothing but an operation could bring the hoped for relief, the operator would not be called upon to treat such desperate cases as those reported. No operator is justified in leaving an abdominal opera-

tion incomplete, except in malignant disease, for the reason that all other growths can be removed, and it should be done when once attempted. As long as the general practitioner persists in pursuing what he pleases to call conservative treatment in these cases, and keeps the patients under his care just as long as he can keep breath in them, and surgeons of the older class turn these patients from their consulting rooms as non-operative cases and thus defer it, or the cases made still more complicated by incomplete operations, men engaged in this special work will continue to see just such desperate cases. While this state of affairs exists, what can we hope for other than a high mortality in these delayed cases, and who should be held responsible for the deaths?

Dr. M. Rosenwasser, of Cleveland, wished to protest against the assertion that these intestinal adhesions were due to the first operation. Intestinal adhesions are common to the broad ligament, and not to the cyst, and will be found there whether you operate the first time or the second time. He also wished to contradict the assertion that these cysts ought to be removed. It is better occasionally not to attempt removal. In some cases it is much better to stitch the cyst to the abdominal wall and drain, leaving the cyst wall alone.

Dr. H. O. Marcy, of Boston, said that in a certain class of cases he had felt that we must stitch and drain. In another class of cases you can readily get behind it, close it down by suturing, and close your wound as in a simple operation.

Dr. W. W. Seymour, of Troy, called attention to the method, suggested originally by Hegar, of approaching these collections of pus through the ischio-rectal space. There is the advantage of not invading cavities not ordinarily septic.

Dr. Hall, closing the discussion, stated that the first case illustrated very forcibly the advisability of an operation on these cases of repeated attacks of inflammation early,—as early as it is found that nothing but an operation can cure them. These cases further illustrate what Dr. Price has said, that we get the worst class of cases among the best class of patients, those of refinement and culture.

Third Day—Afternoon Session.

Dr. Charles A. L. Reed, of Cincinnati, presented

Observations on the Surgical Management of Pelvic Abscess.

Pelvic abscess implies an accumulation of pus within the pel-

vis, but outside of the uterine appendages. Pus within the appendages is known either as pyosalpinx or ovarian abscess, as the case may be. The terms are not interconvertible. The old pathology, which represented every accumulation of pus within the pelvis as cellular in its origin and location, was pernicious; but to deny the existence of such cases is wide of the truth, and to treat all intrapelvic pus cases as tubal or ovarian is likewise pernicious. Three illustrative cases were given in which the abdomen had been opened for pus tubes, but the appendages found free from disease. The pus was found within the cellular tissue and broad ligament, and was evacuated by incision along Poupart's ligament. The suggestion for surgical management consists in adopting this operation as a line of practice. By this means we are enabled to treat the appendages, if diseased, and we are enabled to place the field of operation under complete control.

Dr. Paul F. Mundé, of New York, present by invitation, said that he felt diffident about rising to this question, although he had just said to Dr. Reed that it was a subject he felt very strongly upon and one which he had had considerable experience with. He quite agreed with Dr. Reed. There are many gentlemen who believe that laparatomy is the only thing. There are many who maintain that there is no such thing as pelvic abscess—abscess of the pelvic cellular tissue; everything must come from the tubes; everything is necessarily a pyosalpinx, and could only get into the pelvic tissues secondarily. He did not believe anything of the kind. He knew there were gentlemen who believed it. From his own experience he could see no reason why there should not be just as much plastic exudation between the layers of the broad ligament, or wherever there is cellular tissue in the pelvis, as in any other part of the body where there is cellular tissue. We have boils and abscesses in other parts of the body, and why should we not have them in the pelvis? Besides, we know we have effusions of blood in the pelvis. We know also that ovarian tumors and fibroid tumors develop in the broad ligament, and dissect up the peritoneum almost as far as the diaphragm. Why should plastic material from the blood not be exuded between the layers of the broad ligament and into the cellular tissue? That granted, why should it not break down and become pus? Lawson Tait has taught us to recognize these conditions of pus in the peritoneal cavity by bimanual examination without opening the abdominal cavity. The differential diagnosis is not always an easy one to make. When-

ever a collection of plastic lymph in the pelvic cavity is immovable, it is usually extraperitoneal, and the same would apply to a fluctuating mass containing either pus or blood; when there is a limited movability to it or a limited movability to the uterus, particularly when pulled downward or upward, it was intraperitoneal.

Dr. Joseph Price, of Philadelphia, presented

A PLEA FOR EARLY HYSTERECTOMY AND PUERPERAL HYSTERECTOMY.

The history of abdominal and pelvic surgery is all aglow with the heroic effort, the personal sacrifices of its pioneers. Surgical invention has greatly improved upon and simplified methods. Where the spirit of innovation has bungled, the better genius of surgery has corrected. We are having cleanliness without the aid of chemical irritants and disinfectants. We are rapidly advancing to accept early operation as a dictum in pelvic and abdominal surgery. I can find no delight in so-called conservative methods. My experience disproves and condemns them. It will become an axiom of surgery not to delay longer than to establish the fact that operation will be necessary at some time. This granted, the earlier such operation is done the fewer will be the complications, and all the dangers attending operation will be diminished or avoided. There will be a shorter operation, less handling of the parts, less shock, surgical and dynamic, and quicker convalescence.

The simple entering the abdomen is without danger in the hands of experienced men. Now, when surgical experience proves that the simpler the operation the less dangerous it is, and that the danger increases by exact gradation as the complications increase, what other conclusion to the argument is there than to demand early operation for conditions that in almost all cases eventuate seriously? This is especially true in fibroid tumors. The removal of the appendages is proven to be efficient, in a majority of cases, in controlling hemorrhage, just as it is the clinical testimony that in almost all cases of fibroid disease there is real disease of the ovary itself. In large tumors the ugly nature of the complications, combined with the gradually increasing discomfort, is such that makes delay criminal. We must operate before the patient is past help, if we would save her. Surgery as a last resort after temporizing has failed is no criterion of what surgery can accomplish, and is no measure or standard by which it may be judged.

At an executive session the following officers were elected: *President*, Dr. A. Vander Veer, of Albany; *Vice-Presidents*, Dr.

H. E. Hill, Saco, Me., and Dr. R. T. Morris, New York; *Secretary*, Dr. William Warren Potter, Buffalo; *Treasurer*, Dr. X. O. Werder, Pittsburg; *Executive Council*, Drs. C. A. L. Reed, Cincinnati; Lewis S. McMurtry, Louisville; George H. Rohé, Baltimore; James F. W. Ross, Toronto; and William W. Seymour, Troy.

The following-named physicians were elected to Fellowship:

Honorary—Dr. George Jackson Fisher, Sing Sing, N. Y.; Dr. Gratz Ashe Moses, St. Louis (transferred from Ordinary Fellow); Dr. Juan M. Rodriguez, City of Mexico; Dr. Juan Santos Fernandez, Havana, and Dr. E. Pietranera, Cordova, Argentine Republic.

Corresponding—Dr. Henry S. Griffin, Hamilton, Ont., Canada, and Dr. Henry T. Machell, Toronto, Ont., Canada.

Ordinary—Dr. I. H. Cameron, Toronto, Ont., Canada; Dr. Henry Gibbons, Jr., San Francisco, Cal.; Dr. Frances L. Haynes, Los Angeles, Cal.; Dr. John R. Haynes, Los Angeles, Cal.; Dr. J. B. S. Holmes, Rome, Ga.; Dr. Henry Howitt, Guelph, Ont., Canada; Dr. George Ben Johnston, Richmond, Va.; Dr. Willis G. Macdonald, Albany, N. Y.; Dr. James McCann, Pittsburg, Pa.; Dr. R. Barrington Nevitt, Toronto, Ont., Canada; Dr. George S. Peck, Youngstown, O.; Dr. Edmund M. Pond, Rutland, Vt.; Dr. William Porter, Jr., Hartford, Conn.; Dr. E. Arnold Praeger, Nanaimo, B. C.; Dr. Charles N. Smith, Toledo, O.; Dr. Edwin Walker, Evansville, Ind.

St. Louis was selected as the next place of meeting and the date fixed upon was the 3d Tuesday of September, 1892.

THE MEDICAL SOCIETY OF NIAGARA COUNTY.

At a meeting of this Society, held December 25, 1891, at the office of Dr. Foote, to take action in relation to the death of Dr. Simeon Tucker Clark, the following-named members were present: Drs. Gould, Ransom, Palmer, Hill, John and E. J. Foote, Hodson, Baker, Johnson, Durand, Ready and Loomis.

Dr. Gould was called to the chair and spoke as follows:

Gentlemen: The sorrowful occasion which has called us together this morning is one that but too sadly and truly emphasizes the words of the Psalmist, "There is but a step between us and death." But a few days since, the robust manly form of our beloved brother was present on our streets and in the homes of many families in our city and vicinity, in the active pursuit of his professional duties, which he loved so well; in the discharge of which he manifested a zeal

and earnestness of purpose that must ever accompany a due sense of the responsibility involved in their faithful discharge. To attainments of a high order he combined the kindlier sympathies of our nature and the pleasing address so essential to win confidence and insure success. His poetic genius, his knowledge and love of music, his extensive and diversified reading were all so many sources from which to draw for the benefit of those entrusted to his care. That these qualifications were appreciated by a discriminating public, the large patronage he enjoyed most fully attests. The intense interest manifested as to the issue, after he was stricken down, by all classes in the community, till death closed the scene and paralysed all hope, is too well known for comment. As a member of our Medical Society, as a professional brother, counselor, and friend, this Society and the profession have met with an irreparable loss.

His cordial greeting and pleasant smile, his friendly aid and valued counsel are ours no more, save in the sacred memories of the past.

Of his literary merits and productions, of his position in the medical college of a neighboring city, where he filled a professor's chair I leave others to speak, who are better qualified to judge. For the profession it was a sad but pleasing duty to render all the aid in our power to our stricken brother; and at his bedside, with the beloved wife and children, to mingle our tears in heartfelt sympathy and sorrow; while in Christian faith we resignedly awaited His will who doeth all things well. And thus, as it were, entering "The valley of the shadow of death," awaiting "the inevitable hour that soon or late must come to all," we accompanied our brother to the cold dark waters of the river which separates time from eternity, and peering with tear-bedimmed vision beyond the confines of time, we caught glimpses of the "Shining shore," and heard the strains of celestial harmonies that came from the angelic escort of the spirit departed to the throne of God and the mansion on high.

Farewell, dear brother! Be it yours to bask in the sunshine of redeeming love; to enjoy the rapture of reunion with loved ones gone before. Unfettered by the limitations of time and sense, how shall thy freed spirit glory in the possibilities of an endless life – in the fruition of knowledge that shall come with the never-ending cycles of eternity; in the joy and friendship of pure spirits that is never broken; in the ecstasy of delight that comes to the redeemed in the presence of the Christ whose advent to earth was heralded by angelic hosts, proclaiming "Glory to God in the highest, peace on earth, good will to men!" Shall Christmas time on earth be less joyful because of thine absence? Nay; let us rejoice to feel that while we are yet subject to the sorrows and disappointments of earth, thou art in His presence where is fulness of joy, at His right hand where are pleasures forever more.

Adieu! dear brother, not a long, but a brief adieu.
And this our prayer, who still remain,
God be with us, till we meet again.

Drs. Palmer, Ransom, Baker, Johnson, and Loomis also paid feeling eulogies.

The following Committee on Resolutions was appointed: Drs. Kittinger, Palmer, and E. J. Foote, who reported as follows, the report being adopted:

MEMORIAL.

As with noble work well done, our beloved frater and brother co-worker, Simeon Tucker Clark, has folded his willing weary hands in peaceful rest, in the full noontide of ripened manhood, to solve the mysteries of the higher life, glimpses of the bright radiance of which he had so often caught and penned, to brighten the pathway of us who shall come after; as the love-work of a life ever employed to smooth the pillow of the distressed and afflicted has thus suddenly and unexpectedly ended, leaving only cherished memories and saddened hearts;

As a trusted counselor, possessing an educated intellect and ripened experience of priceless value, coupled with a grace, willingness, refinement, tender consideration, and disinterested friendship which few possess and all may emulate, has left his place vacant, and vacant, as well, a place in every heart;

As a bright social link in the burnished chain of fraternity and companionship lies broken and shattered beneath our feet;

As a ready, skilful, helping hand is missed in our necessities;

As a heart, bubbling over with human sympathy, kindness, and good-will to all has ceased to pulsate;

As the voice of a sweet singer of melodious minstrelsy, that sang of purity and love by sweet inspiration from the fountains of life and light, has died away from our listening ears;

As a Christian gentleman, whom we loved, revered, and honored, has left our hearts lonely and desolate;

We are left to sincerely mourn, and to extend our heartfelt sympathies to those dear ones who, by the closer relationship of husband and father, have become so unmeasurably and sorely bereaved by this untimely affliction, and we most sincerely, hopefully, and devoutly commend them to that divine and boundless source of all consolation, comfort, and blessings which he, for whom we are bereaved, so sincerely reverenced and trusted.

But while with them we deeply deplore the irreparable loss they have sustained, we also most reverently desire with them to rejoice for a victory won, a life well done; to rejoice with them in the blessed assurances which are vouchsafed to us all, that —

Not "Down to Emmanus" with blinded eyes,
He walks today
In mortal clay;
But hand-in-hand, in glad surprise,
He walks today
With Christ the way.

Resolved, That this memorial be engrossed as a part of the minutes of the Niagara County Medical Society, and that a copy be transcribed and transmitted to the family of the deceased, and that the local papers and the BUFFALO MEDICAL AND SURGICAL JOURNAL be furnished with a copy for publication.

Progress in Medical Science.

MEDICAL JURISPRUDENCE.

Conducted by HENRY A. RILEY, A. B., LL. B., New York.

PHYSICAL EXAMINATION OF LITIGANTS.

THE Supreme Court of the United States recently decided that the Federal courts have no power to compel the plaintiff in an action for personal injuries to submit to a surgical examination, and the *Albany Law Journal* comments as follows:

It is difficult to accept the argument that a party may be compelled to produce particular evidence against his will, simply because he had the right to produce it if he wishes.

It seems clear to us that the true reason of the case has not been clearly propounded in either of the opinions, nor anywhere else, so far as we have read, excepting once. The court has no power to compel the suitor to produce any particular piece of evidence. He is suing for his own benefit, and may put in such evidence as he choose, taking upon himself the burden of satisfying the jury.

The jury may lean against him, because of his omission to produce certain available evidence, but the court has no more power to compel his exposure of his person to a surgical examination than to compel his production of a particular witness to the transaction in question, whom he omits or refuses to produce. This last class of omission is frequently commented on by opposing counsel as suspicious, but no one ever claimed that the party could be obliged to produce such evidence.

BUFFALO AND ITS HEALTH DEPARTMENT.

THE revised charter of the City of Buffalo contains numerous provisions in regard to the Board of Health and its duties, some of which may be of interest to those who have not personally examined the new law.

The Board of Health consists of three members, the Mayor, the

President of the Board of Public Works, and the Health Commissioner.

The latter holds office for five years and must be a reputable and licensed physician, at least thirty years of age, and having an active experience as a practising physician of not less than five years.

The Health Commissioner has supervision over the care, removal, burial or incineration of the dead, the registration of births, marriages and deaths, of vital statistics, and with the approval of the Board, may make such rules and regulations as are necessary for the protection of the public health. The city is divided into eight health districts, for each of which a physician in good standing is to be appointed.

He is to have the title of city physician.

In addition there are to be two homeopathic physicians whose districts are to be designated by the Board.

It is the duty of the city physicians to render all necessary medical services to indigent sick persons in their districts, and report to the Board of Health all nuisances or unsanitary places, or any violations of health ordinances which may come under their notice.

The Board of Health has full power to abate nuisances, to take proper measures to prevent the entrance of pestilence or infectious diseases, and to stop persons coming from infected places and remove them to quarantine hospitals. It can disinfect buildings, vessels, clothing, etc., or destroy the same. The plans of all buildings to hold more than three families, of slaughter houses, livery stables, etc., etc., are to be submitted to the Board. The drainage and plumbing of public and private buildings must be according to plans approved by the Board. It is the duty of the Health Commissioner to visit all hospitals where patients supported by the city are received, at least once a month.

THE GRIP AND THE LAW.

The English papers have just reported that the grip, or influenza, as it is termed in the cable dispatches, is so much of an epidemic that the authorities are attempting to stamp it out by a vigorous application of the laws relating to the public health.

These laws make it an offense for a person suffering from a contagious disease to visit public places. As the influenza seems to be

regarded as a contagious disease, a number of persons have been arrested for violating the law, and have been fined $25 each.

It is said that this is the first instance in England of persons suffering from influenza being fined for endangering the public health by coming in contact with persons in the streets or public places.

It is not known that any attempt has been made in this country to suppress the grip by fines.

IS ELECTRICITY MANUFACTURED ?

THERE has recently been a curious decision in Pennsylvania in reference to electricity.

The Northern Electric Light and Power Co. furnishes electricity for power or for illuminating and heating purposes to its customers, and it claimed to be a manufacturing company, so as to get the benefit of an act exempting the capital stock of such companies from taxation. The company, without question, generated electricity, stored it, disposed of it in quantities to suit purchasers, and was paid for so doing. It was claimed, however, that it did not manufacture electricity in the sense that term was used by the public and understood by the legislature at the time the act was passed in 1885, and the court adopted this view, holding the company liable to taxation.

MEDICINE.

By WM. C. KRAUSS, M. D.

ICHTHYOL IN THE TREATMENT OF DYSPEPSIA AND CEPHALALGIAS.

DR. STOCQUART, of Brussels, in experimenting upon ichthyol, says that it will relieve the pains of dyspepsia and of neuralgias. It is more active than the bromide of potash, better supported by the the stomach, improves the appetite, and hastens digestion. The dose, as recommended, is 0.50 centigrams daily.—*Le Progrès Médical.*

A CASE OF CHOREA CURED BY EXALGINE.

THE patient, a child of eight years, who had been afflicted for a month, was relieved from the very onset by exalgine, and cured in the space of eighteen days. Twenty centigrams were given daily

for a week and 30 centigrams after this time.—Dr. Moncorvo in *Le Progrès Médical.*

THE ACTION OF ICE AND ICE WATER IN DIPHTHERIA.

The treatment of diphtheria as employed by Dr. Bleyne consists in the application of ice upon the neck, and the internal use of ice. If ice is not obtainable, water as cold as possible may be used instead. The author claims that cold destroys the bacillus of diphtheria.

THE ACCUMULATION OF BROMIDE OF POTASH IN THE DIFFERENT TISSUES.

Féré and Herbert, of Paris, have recently made some interesting experiments on this point and transmitted their report to the Société de Biologie. An epileptic, aged 64, began December 18, 1890, with 5 grammes daily of potassium bromide, then took six grammes daily, and, beginning October 13, 1891, 7 grammes daily until October 20, 1891. On October 23d he died with pneumonia. The various tissues of the body were then carefully examined and found to contain, per 100 grammes, the following quantities of the salt: brain, 0.073; lungs, 0.082; liver, 0.104; spleen, 0.133; kidneys, 0.10; pancreas, 0.043; muscle, 0.062; cartilage, 0.041; bone, 0.087.

MODIFICATIONS OF THE PULSE OF THE BRAIN AND FOREARM DURING THE ADMINISTRATION OF SULFONAL.

Dr. Sgobbo Francesco, of Naples, in making a series of observations, published in *Annali di Neurologia, Fac. II.*, 1891, came to the following conclusions:

1. That sulfonal is a good hypnotic.

2. That given in doses of 3 grammes it exhibits an action over the heart and blood-vessels, reinforcing the systole and increasing the vascular tone of the arteries. This action upon the vessels is not continuous, for after a certain time there is dilatation and a progressive loss of elasticity, beginning first in the vessels of the brain, then extending to the periphery. The alterations in the vessels stand in relation to the amount of the drug taken.

the room to perform Cesarean section on the corpse, with a view of saving the child. The operation was successful, but the operator was brought before the magistrate and fined fifteen francs for having been guilty of illegal practice of medicine."

Selections.

A NEURO-TOPOGRAPHICAL BUST.

By WILLIAM C. KRAUSS M. D., Buffalo, N. Y.

A NEURO-TOPOGRAPHICAL bust needs be one showing the topography of the nervous system of the head and neck on a model closely resembling that of the human form. It seemed to me that a bust constructed on these lines would be of great benefit to the neuro-specialist as a means of reference and comparison, while to the teacher it would serve as an important aid in the elucidation of facts in class-room demonstrations.

With these objects in view, a bust was modelled in plaster, life size, offering the following special features:

The fissures of the brain are represented by grooved lines, deep or shallow, according to the size of the respective fissures in the human brain. In order to render them more distinct and visible, they have been traced in black. These lines are not intended to represent accurately the intricate windings of the various fissures, but only the general outlines and the relations of the various fissures to one another.

The position of the several centers presiding over the functions of the body, as far as known, could be easily designated on the bust, thus keeping before our eyes the brilliant achievements constantly being made in this branch of our science.

The face and neck represent the various electro-motor points of the muscles and nerves as determined by Erb, v. Ziemssen, *et al.* The motor points of the trunk and various branches of the trigeminus, the hypoglossal, accessorius, etc., are indicated by circles slightly raised, which, in order to make them more apparent, have been painted yellow. The course of the phrenic nerves, and the several trunks of the brachial plexus in the neck are marked by slightly grooved lines, also painted yellow.

1. Exhibited at the meeting of the American Neurological Society, Washington, D. C., September 22, 23, and 24, 1891.

In contrast to the nerves, the motor points of the muscles are represented by smaller circles, which have been painted red.

The designation of the various points has been purposely omitted on the bust, but may easily be done, either by small printed slips, or by figures and a reference table.

The work of the moulder, Mr. Gustave Freret, of 155 East 50th street, New York, has been skilfully and well done, and he is prepared to furnish duplicates at any time.

EXPLANATION OF PLATE.

CRANIAL REGION.

1. Sylvian fissure. 2. Central fissure (Rolando). 3. Parietal fissure. 4. Occipital fissure. F1. Superior frontal convolution (superfrontal). F2. Middle frontal convolution (medi-frontal). F3. Inferior frontal convolution (subfrontal). Fa. Ascending frontal convolution (precentral). Pa. Ascending parietal convolution (postcentral). Ps. Superior parietal convolution (parietal). Pi. Inferior parietal convolution (subparietal). A. Angular convolution. T1. Superior temporal convolution (supertemporal). T2. Middle temporal convolution (meditemporal). T3. Inferior temporal convolution (subtemporal). O1. Superior occipital convolution. O2. Middle occipital convolution. O3. Inferior occipital convolution.

FACIAL REGION.

1. Trifacial nerve; superior branch. 2. Trifacial nerve; superior branch. 3. Trifacial nerve; middle branch. 4. Trifacial nerve; middle branch. 5. Trifacial nerve; trunk. 6. Trifacial nerve; inferior branch. 7. Trifacial nerve; inferior branch. 8. Hypoglossal nerve. 9. Accessorious nerve. 10. Erb's point (supraclavicular point). 11. Phrenic nerve. 12. Brachial plexus. 13. Axillary nerve.

MUSCLES.

a. Frontalis. b. Corrugator supercilii. c. Orbicularis palpebrarum. d. Nasal muscles. e. Zygomatic muscles. f. Orbicularis oris. g. Masseter. h. Levater menti. i. Quadratus menti (depressor labii inferioris). k. Platysma myoides. l. Hyoid muscles. m Sterno-cleido-mastoid. n. Omo-hyoid. o. Splenicus. p. Trapezius. r. Levator anguli scapuli. s. Triangularis menti (depressor anguli oris). t. Stylo hyoid. u. Digastric.

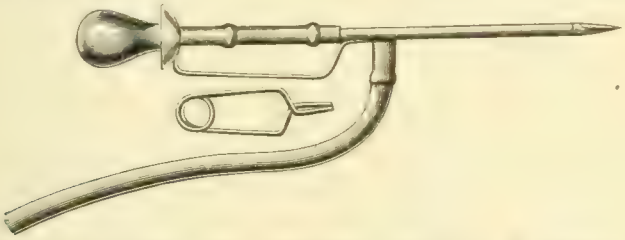
—*Journal of Nervous and Mental Diseases.*

New Instruments.

A PLEURA-TROCAR.

By MARCELL HARTWIG, M. D., Buffalo, N. Y.

This instrument, which I have recommended and described in the *Medical Record* of January 17, 1891, page 80, has served me practically for years. I have been satisfied with it every time, so that I can heartily recommend it to the profession. It admits perfect



antiseptising (boiling), and excludes the air. A pump is not needed. About four feet of rubber tubing will syphon the pleural cavity perfectly.

Oil the stylet with an antiseptic vaseline, and compress the rubber interstice gently with two fingers while withdrawing the stylet. Keep up the compression with the hand holding the trocar; a light clamp can substitute the fingers. At a time when the diagnosis of pleural exudation becomes possible, there is probably always pressure enough in the pleural cavity to expel the air from the syphoning tube.

For safety's sake, though, the tube should be filled with an antiseptic fluid, when the trocar is plunged into the intercostal space in order to start the syphoning, while the end of the tube dips into the same fluid in a dish on the floor, and always test the perfect fitting of the rubbers with water before beginning an operation. Of course, injection can be made through the same tube.

Stoddard Bros., of Buffalo, have constructed the trocar to my entire satisfaction.

He was no Fly-Roost.—Shingler—"I have called to ask your daughter's hand in marriage."

Prospective Pa—"But you are an unknown doctor, without sufficient income to support her, and the ethics of your profession forbid you to advertise."

Shingler—"Yet I am no fly-roost. I have let three rooms over my office to reporters, have given them free use of my telephone, and have joined the Press Club."—*Munsey's Weekly.*

BUFFALO MEDICAL AND SURGICAL JOURNAL

A MONTHLY REVIEW OF MEDICINE AND SURGERY.

EDITORS:

THOMAS LOTHROP, M. D. - - WM. WARREN POTTER, M. D.

All communications, whether of a literary or business character, should be addressed to the managing editor: 281 FRANKLIN STREET, BUFFALO, N. Y.

VOL. XXXI. MARCH, 1892. No. 8.

THE MEDICAL SOCIETY OF THE STATE OF NEW YORK.

THE eighty-sixth annual meeting of this Society, which was held in Albany, February 2, 3, and 4, 1892, was in all respects an interesting and profitable gathering. The meetings of this Society have increased in interest very much during late years, and the recent one has kept pace with a large group of its predecessors in respect to number in attendance, value of the scientific work done, and agreeableness of its social entertainments.

The President of the Society, Dr. A. Walter Suiter, of Herkimer, acquitted himself with great credit as an executive officer, and it must be confessed that his inaugural and anniversary addresses were among the best ever heard from the chair of this Society. The inaugural showed great familiarity with the affairs of the profession in this State, and it dealt with all questions of medical polity with much acumen and rare discretion.

The Pan-American Medical Congress received due attention, and the recommendations of the President were indorsed by the Society creating a committee of seven to carry out any regulations imposed upon the Society by the officers of the Congress and to place the Society in every way *en rapport* with the Congress.

Dr. Samuel B. Ward's dinner, on Monday evening, to the ex-presidents of the Society, was a delightful gathering of genial men, who passed three or four hours together in a most agreeable manner.

It has come to pass, of late years, that the Society really begins its meetings on Monday evening, when many of the preliminaries are arranged, and at which time the credentials committee commences its work. This is wise, for it relieves the pressure on this committee in the early hours of Tuesday.

Much disappointment was expressed at the failure to attend of several prominent men from the West and South-west, whose names were on the programme.

The scientific part of the meeting reached its climax on Wednesday afternoon, when the paper of Dr. Wylie was read, and the interest finally culminated in the brilliant discussion that followed Dr. Mordecai Price's paper on Drainage in Abdominal Work, which lasted until 6.30 P. M.

Considerable interest was felt on the subject of the State Examining and Licensing Board, and a brief report was made with reference to its work during the current year. A special committee was appointed by the Society to attend the hearing on a so-called Students' Exemption Bill, introduced by Senator O'Connor, and known as Senate Bill No. 145. We understand that certain students have employed a "professional legislator," who has agreed to obtain their exemption from the provisions of the State Examiners' law for the sum of $5,000; or, failing to accomplish this, he is willing to accept $1,200, or about $100 a month during the term of the Legislature. It seems to be difficult, in the State of New York, to obtain any improvement in reference to the methods of conducting its affairs without encountering the most covert and determined methods of opposition. It is difficult to understand on what grounds of right or justice a demand for further exemption is made, but we shall be perfectly willing to have the law amended, as asked, providing it will direct the word "Exempt" to be stamped in indelible letters across the foreheads as well as the diplomas of every student who is engaged in this nefarious scheme. In this connection we desire to call attention to an editorial in the *New York Medical Journal*, February 13, 1891, which ought to be read by every friend of medical improvement, and ought to be committed to heart by every student who is seeking an exemption. We indorse what the accomplished editor of the journal referred to has written on this subject, and commend it to the legislative and executive authorities at Albany.

The Society elected the following officers for the ensuing year: *President*, Dr. Lewis S. Pilcher, of Brooklyn; *Vice-President*, Dr. H. L. Elsner, of Syracuse, N. Y.; *Secretary*, Dr. F. C. Curtis, of Albany; *Treasurer*, Dr. C. H. Porter, of Albany. Standing Committees: On *Arrangements*, Herman Bendel, Seneca D. Powell, and Nellis; *By-Laws*, A. R. Simmons, W. C. Wey, and Curtis; *Hygiene*, Laurence Johnson, Brush, Bell, Burr, Balch, Herman, and

Peck; *Legislation*, D. B. St. John Roosa, Daniel Lewis, and Lewi; *Ethics*, A. Jacobi, A. Matheson, and J. H. Glass; *Prize Essays*, Geo. H. Fox, W. W. Potter, and Roe; *Publication*, Curtis, Potter, Porter, and Bailey. The following named were elected *Honorary Members:* Dr. Lewis S. McMurtry, of Louisville, Ky.; Dr. Charles A. L. Reed, of Cincinnati, O.; Dr. William E. B. Davis, of Rome, Ga.; Dr. Adam H. Wright, and Dr. James F. W. Ross, of Toronto, Ont.

THE STUDENTS OF NIAGARA UNIVERSITY SPEAK.

The following action of the class of 1893 of Niagara Universty, on the Exemption Bill now pending in the Legislature, is commended to the consideration of the faculties of the several medical colleges of the State as a model. Like father, like son; like teacher, like pupil. All honor to Niagara University students, say we:

Whereas, The Legislature of the State of New York in 1890 passed an act entitled: "An Act to Establish Boards of Medical Examiners of the State of New York, for the examination and licensing of practitioners of medicine and surgery and to further regulate the practice of medicine and surgery."

And whereas, We are informed that an amendment to Section 11 of said act has been introduced and is now being considered by the present Legislature of the State, the object of which is to exempt graduates of 1893 of all medical colleges in New York State from an examination by or before such Board of Examiners.

And whereas, An amendment to said Section 11, exempting the class of 1892, passed the last session of the Legislature, and the present amendment embodying the same object for the class of 1893, thereby perpetuating same, rendering the law inoperative and of no value.

And whereas, The proposed amendment is applicable to us as the class of 1893, relieving us from the provisions of the above act, but which in our opinion is most unwise; and any act or law which will elevate the standard of medical training, should be hailed with delight by the people of the Empire State, or any State, and also by the professors who fit the students with the knowledge to combat the evils to which flesh is heir.

Now, therefore, We, the class of 1893 of the Medical Department of the Niagara University of Buffalo, N. Y., recognizing the fact that persons intrusted with, and upon whose learning, judgment and skill depends human life, cannot be too well equipped or too well fitted for the most important duties which the physician is called upon to discharge.

And further Recognizing the wisdom of the appointment of such

a Board of Examiners, protest against the proposed amendment to Section 11 of Chapter 507 of the Laws of the State of New York, passed in 1890.

And be it Resolved, That we request our representatives in the Legislature to oppose the passage of, and if possible defeat such amendment.

The Class of 1893 by

P. H. HOURIGAN, *President.*
FRED M. BOYLE, *Secretary.*

D. L. DALY,
D. F. WHITE,
H. J. NEWTON
J. A. BLAIR,
} *Committee on Resolutions.*

NOTES AND COMMENT.

THE last annual report of the Postmaster-General presents an admirable showing in this important department of the public service. There is nothing nearer to the hearts of the people than its postal system, and the steady improvement of the letter service has been marked during the last twenty-five years. Not so, however, with reference to the newspaper and magazine branches. Here there is more incongruity of ruling and less harmony of action than in any section of the public service with which we are familiar. Some of these peculiarities are admirably set forth in a recent number of *Printers' Ink*, published by Geo. P. Rowell & Co., New York, and it would well repay all interested to carefully read what this admirable little paper says on the subject. One of the peculiarities of the service, which has always perplexed us to understand, is why a newspaper or magazine, for instance, can be sent from Buffalo to California for one cent a pound, whereas it costs two cents for every four ounces to deliver the same journal to a subscriber living in the city of its publication. In connection with the Postmaster-General's report it may be mentioned that he has published some admirable photographic reproductions of the late disaster on the Lake Shore Railway, whereby six postal clerks lost their lives. It is a graphic exhibition of the perilous nature of this service, and appeals to the sympathy of all mankind.

A DISPATCH from the Immigration Commissioner at New York assures Dr. Wende, the Health Commissioner, that none of the

passengers who made the voyage on the "Massilia" were ticketed to or through Buffalo; hence it would appear that there is little danger of the typhus gaining foothold in the city from that source. However, it was a wise precaution that led Dr. Wende to appoint two competent physicians to inspect the incoming trains with reference to the possibility of their bringing into or through our city passengers who were infected with contagion. It is much easier to prevent than to cure, and no one will object to the strongest lines of preventive management, even though sometimes it seems to involve a useless expense. There is no waste of money when used in this manner, and we commend the prompt action of the Health Commissioner in this instance.

The *Texas Sanitarian* is a handsomely printed journal that appeared in November, 1891, as the advocate and champion of preventive medicine and hygiene. It is published at Austin, Texas, and is edited by Dr. T. J. Bennet, who seems to have an entire fitness for the position which he has assumed. There is no more important department of medical literature than that referring to sanitation and hygiene. We congratulate this new candidate for the high stand which it has taken, both as to the material which it presents and the method of its presentation.

The Western Society of Obstetricians and Gynecologists met for organization at Topeka, Kansas, December 29, 1891. Dr. M. B. Ward, of Topeka, was elected President, and the usual number of associate officers were chosen. This association is organized especially in the interest of men residing west of the Missouri river, for the investigation and study of the subjects covered by its title. The first meeting was a large and enthusiastic one, and we bespeak a successful career for the association.

The *Ohio Medical Journal*, which is the organ of the faculty of the Medical College of Ohio, appears on our table for the first time with its January number. It is a well-printed and good-looking organ, but has the disadvantage of being oversize. We wish that there could be some uniform standard of size adopted for medical journals. On the whole, the standard octavo seems to be the favorite, as it is best adapted to library shelves after binding.

THE *Hot Springs Medical Journal*, the first number of which was published January 15, 1892, comes to our table as an exchange. We hope it may be the means of improving the *esprit de corps* in the profession at that health resort.

THE *Albany Medical Annals* put on a new dress with the beginning of the year, and appears with a new editor at the helm. Dr. Howard Van Rensselaer will in the future conduct this able and progressive journal.

THE *Post-Graduate*, with its December issue, began a new series as a monthly. It is a progressive journal, and is always full of interesting reading matter.

Personal.

DR. A. F. O'HARA has been appointed keeper of the Quarantine Hospital under the new health régime. Dr. Wende is exercising rare skill and judgment in the selection of his appointees, and this last mentioned one is to be commended on all hands as an improvement over the former system, whereby a non-professional man was kept in charge of that department of the public health service.

DR. RICHARD A. HEATH, of Wadsworth street, is the first physician in Buffalo to obtain the State license to practise medicine and surgery under the recent law creating a State Medical Examining and Licensing Board. Dr. Heath also enjoys the further distinction of being the only physician in Buffalo to possess a State license up to the present date. Dr. Heath is not an exempt.

DR. WM. C. KRAUSS, Professor of Pathology, and Dr. John A. Miller, Professor of Chemistry, in the Medical Department of the Niagara University, have been elected Fellows of the Royal Microscopical Society of London.

DR. WALTER COLES was lately elected President of the St. Louis Medical Society for the ensuing year. The Society is to be congratulated upon this admirable selection.

Dr. Wm. B. Southard was recently chosen President of the Kalamazoo (Michigan) Academy of Medicine. The annual meeting of the Academy was held February 4th, at which time Dr. Heneage Gibbes, of Ann Arbor, read a paper on Formation of Cavities in the Lungs. It was an ample discussion of this important and interesting subject.

Dr. William H. Heath has been appointed inspector of food and drugs by the Health Commissioner, Dr. Ernest Wende. Whatever can be done in the official inspection to give the citizens of Buffalo pure food and drugs, will be done under the present administration of the Health Department, as instanced by this excellent appointment.

Dr. Byron Stanton was elected President of the Cincinnati Obstetrical Society for the ensuing year, at the last annual meeting of that efficient medical organization. This is a fitting honor for the Society to bestow upon one of its most faithful and capable members.

Book Reviews.

Physicians' Leisure Library. Pulmonary Consumption a Nervous Disease, Considered as such from a Practical, a Clinical, and a Therapeutical Standpoint. By Thomas J. Mays, M. D., Professor of Diseases of the Chest in the Philadelphia Polyclinic and College for Graduates in Medicine; Visiting Physician to the Rush Hospital for Consumption, of Philadelphia; Member of the Philadelphia County Medical Society; Member of the Neurological Society of Philadelphia, etc., etc. Detroit, Mich.: George S. Davis, Detroit, Mich. 1891.

This essay is an attempt to substitute for the bacillus theory one showing that the origin of consumption is in the nervous system.

The argument is based on these facts: first, that the children of consumptives are often hysterical; second, that many cases of pulmonary disease have been associated with diseases of the vagi, with bulbar paralysis, disease of the medulla, tabes dorsalis, and multiple neuritis; third, that there is a relationship between alcoholism and consumption; fourth, that there is a relationship between syphilis and pulmonary consumption. These last two causes—syphilis and alcohol—he maintains, operate because they both have a special

affinity for the nervous system, and produce the lung lesions through the pneumogastric nerves. Fifth, twenty-four post mortems on epileptics have shown pulmonary disease, and disease either of the vagi or of the medulla oblongata. Sixth, that diabetes, also beri-beri, leprosy, lupus, and pellagra have occurred in the same patients.

The statement that the children of consumptives are often hysterical is true, but we do not see that that warrants the deduction that the nervous disorder in one generation is a proof that the consumption in the parents was a nervous disease. It simply proves to us that invalid persons cannot expect healthy, vigorous children. The children of the aged are not vigorous.

That alcoholism is frequently found in the ancestry of consumptives is a sad fact. But it is sadder still to think that alcoholism is so general and so widespread that we cannot think of any disease that afflicts mankind among whose victims we will not find a certain proportion with an alcoholic ancestry.

We can say of syphilis and consumption that we do not deny the fact that they both affect the pulmonary tissues. We will go farther, and say that they both affect bone, cutaneous and nerve tissue. To us it proves that the germ of these two diseases can flourish in many different soils.

We come now to the question of the relation of epilepsy and consumption. The author starts out with the statement that Vander Kolk, Marshall Hall, Brown-Sequard, Kussmaul and Zenner point out conclusively that the chief seat of epilepsy is located in the medulla oblongata. This statement we deny. They did not prove this *conclusively*, as is shown by the fact that Rosenbach proved that stimulation of the medulla caused tonic and not clonic spasms. He denies the possibility of the medulla being the epileptic center. Opposed to the theory which the author says is conclusively proven, we find such noted experimenters and authorities as Sepilli, Albertoni, Ferrier, Luciani, Bartholow, Unverreicht, Munk, Budnow, Heidenhain, Horsley, and Hare. Thus we see that the corner-stone on which the author is building his fabric is not resting on the solid foundation he would have us believe.

That phthisis and epilepsy may occur in the same patient, no one will deny. So may phthisis and barbers' itch. We do not believe that the coexistence of two diseases in one patient proves that they have the same origin.

The book closes with a description of the treatment of phthisis

according to the theory of the nervous origin of the disease. We had expected in this chapter to find something new, but, on the contrary, we find our old friends. *Rest* for those who become tired on exertion. If they are able, let them walk out and sit in the open air. If not able to walk out, let them be carried out. Antipyrin, antifebrin, and phenacetin for high temperature. A dietary of the most nutritious foods, cod-liver oil, hypophosphites, pulmonary gymnastics, inhalation of oxygen, nitrous oxide, and compressed air.

We find galvanization of the pneumogastric nerves, and painting with iodine along their course recommended. But we find nothing about the results of this treatment. We are left to infer what we please.

The theory of the author is an interesting one, and as we read it we wished we might be convinced, but the weight of evidence is against it, and in our opinion the author has not proved his case.

J. W. P.

MASSAGE, AND THE ORIGINAL SWEDISH MOVEMENTS. Their Application to Various Diseases of the Body. Lectures before the Training Schools for Nurses connected with the Hospital of the University of Pennsylvania, German Hospital, Woman's Hospital, Philadelphia Lying-in Charity Hospital, and the Kensington Hospital for Women, of Philadelphia. By KURRE W. OSTROM, from the Royal University of Upsala, Sweden; Instructor in Massage and Swedish Movements in the Philadelphia Polyclinic and College for Graduates in Medicine. Second edition. Enlarged, with eighty-seven illustrations. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut street. 1891.

So much attention has been given to the so-called Swedish movement and massage of late, that its literature is fast becoming redundant. In reality we see but little difference as to the methods of their professors. Based on the anatomical structure of the body, the intelligent use of either, or both, must be substantially alike.

Ordinary gymnastic exercises aim to give the human frame its most harmonious development, while massage is supposed to be mostly confined to the sick room, and consists mainly in an intelligent manipulation in the line of the course of the blood-vessels, or kneadings and other uses of the hand in starting sluggish capillaries.

While readily admitting the therapeutic value of massage when intelligently applied, we cannot but fear that the author, in

common with other advocates of the system, is too sanguine in regard to its advantages in cases of diseases of the internal organs, especially those which by their anatomical positions and relations would seem to be beyond external manipulation, except, perhaps, in cases of emaciated patients, where absence of fat and muscular tonicity may enable him to effect the part.

In regard to the value of the so-called Swedish movement, whether curative or prophylactic, and which forms the second and, perhaps, more important part of the treatise, it is not too much to say that it addresses itself directly to the reason of the physiologist, and that it is intelligently exhibited by Mr. Ostrom in his little work. One advantage in this form of health-giving gymnastics lies in its applicability to sick and well alike, and that it does not require absence of clothing. By proper and scientific movements of the joints and muscles the flow of blood is accelerated, the reflex action of the nervous system increased, the stimulating effect of which will be felt throughout the whole frame.

So far as we may judge, Mr. Ostrom's directions are clear and those of a man thoroughly acquainted with his subject and its practical application. The illustrations are simple and easily understood, the typography excellent, and the whole forms a handy little book of 143 pages.

AGE OF THE DOMESTIC ANIMALS. Being a Complete Treatise on the Dentition of the Horse, Ox, Sheep, Hog, and Dog, and on the Various Means of Determining the Age of these Animals. By RUSH SHIPPEN HUIDEKOPER, M. D., Veterinarian (Alford, France); Professor of Sanitary Medicine and Veterinary Jurisprudence, American Veterinary College, New York; Lieutenant-Colonel and Surgeon-in-Chief National Guard of Pennsylvania; Fellow of the College of Physicians, Philadelphia; Honorary Fellow Royal College of Veterinary Surgeons, London; late Dean of the Veterinary Department, University of Pennsylvania, etc. Illustrated with 200 engravings. Octavo, pp. 212. Philadelphia and London: F. A. Davis, publisher. 1891.

This book, judging from the moderately critical attention we have been able to bestow upon it, seems to have the merit of fulfilling the promise of its title. The matter of which it treats is one of great importance in a certain sense to all, since we all are so largely dependent on our domestic animals, but especially so to the farmer, to the stock raiser, and, indeed, to all whose business or pleasure requires the possession of domestic animals.

Although the scope of the book takes in the dentition of other

domestic animals, the part of most general interest to the ordinary reader will be found in what relates to the horse, since not only is he, in some sense, man's most useful companion, but it is also the animal whose age is most commonly and most surely determined by the state of his teeth ; hence, it is this part of the subject which forms by far the largest part of the treatise.

Dr. Huidekoper says in his introduction :

We judge of an animal from its general aspect, from the various changes in the conformation of the body, both external and internal, and from the functional activity of its various organs. All of these are to be examined in detail, and the synthesis of the result usually gives an accurate indication of its age. The most important details in judging of the age, especially in the horse, is found in the teeth." * *

And again he says: "In the ox and sheep, again, the teeth are of good value in judging of age, but the epidermic products, in the shape of the horns, are also important factors after they have become adults." In the dog he considers the teeth are valuable in indicating the age only in young animals ; but in older ones, owing to these modifying circumstances, alterations of the epidermic appendages and general aspect must be our guide.

A full account of the dentition, the growth, form, and histology of the teeth of the horse forms a considerable part of the work. Attention is paid to the duration of the life of the animal, and principles for determining its age and character by the teeth are noted. The thirty years which constitute the life of a horse are divided into five successive periods, showing the state of the teeth in each period, and the normal changes by which one may judge. Irregularities are then described and illustrated, as is indeed every part of the work by finely executed wood-cuts, after which the author turns his attention to the cow, the sheep, the goat, the pig, and, last of all, to the dog.

The book is well written and, as above remarked, well illustrated, and makes interesting reading, to say nothing of its general usefulness.

A B C of the Swedish System of Educational Gymnastics. A Practical Hand-Book for School Teachers and the Home. By Hartvig Nissen, Instructor of Physical Training in the Public Schools of Boston, Mass.; Instructor of Swedish and German Gymnastics at Harvard University's Summer School, 1891 ; formerly Instructor of Physical Culture at the Catholic University, Washington, D. C., etc., etc. With seventy-seven illustrations. Philadelphia and London : F. A. Davis, publisher. 1891.

Gymnastic exercises aim to give the human frame its most har-

monious development in every part, so that, like the good deacon's one-horse *shay*, it shall equally bear the wear and tear — whether of mind or body. Any exercise that develops abnormal strength of a part or parts of the body transcends health requirement. It is pleasant to find that tendency of the system taught and advocated in Mr. Nissen's little volume, is wholly within the scope of a proper and intelligent physical culture, and cannot other than be a valuable auxiliary to the school in the training of the young. We speak of a healthy mind in a healthy body as if they were separate parts of man. A well-balanced brain can hardly exist in a feeble frame, since its strength and well-being must depend on the circulatory system, and it is just that which a proper line of gymnastics sets agoing with the greatest likelihood of success.

The work is systematically arranged in the form of a catechism, with the view to the convenience of the teacher, and profusely illustrated by cuts, which in their simplicity and clearness leave nothing to be desired.

THE MICROSCOPE AND ITS REVELATIONS. By the late WILLIAM B. CARPENTER, C. B., M. D., LL. D., F. R. S. Seventh edition; enlarged and revised by the REV. W. H. DALLINGER, LL. D., F. R. S., etc., with twenty-one plates and 800 wood engravings. Octavo, pp. 1099. Philadelphia: P. Blakiston Son & Co., 1012 Walnut street. 1891.

A standard work like Carpenter's text-book on microscopy needs no introduction to the professional readers, no encomiums and no adulations. By the time it has reached its seventh edition all errors will have been corrected, and the work passed on its merits.

In this new edition, revised by Mr. Dallinger, the first seven chapters have been entirely re-written — in part by those who have been instrumental in bringing these changes about; thus the chapters on the Principles and Theory of Vision with the Compound Microscope were carefully reviewed by Prof. Abbe, of Jena; and so in other departments, — the work has been sublet, so that it is more or less cyclopedic in character.

The opening chapters deal with the theory and construction of the microscope, describing accurately the simple microscope of Galileo, Descartes, Campani, through its various stages, until we reach the beautiful instrument of Zeiss, Beck, Bausch & Lomb, Zentmayer, etc., of the present day. The chapters on Methods of Preparation of Material, Staining, Mounting, etc., show that the editor has been a laborious and conscientious student. The chap-

ters following treat summarily of the whole Animal, Vegetable, and Inorganic Kingdoms. But one chapter of fifty pages is devoted to Animal Histology. For the microscopist working in no special field, perhaps no better work can be recommended, but for the histologist, other books are necessary.

The plates are handsomely executed, and add much to the worth of the treatise. W. C. K.

ESSENTIALS OF NERVOUS DISEASES AND INSANITY. Their Symptoms and Treatment. A Manual for Students and Practitioners, by JOHN C. SHAW, M. D. Fifty-eight original illustrations, mostly selected from the Author's Private Practice. Philadelphia: W. B. Saunders, 713 Walnut street. 1891.

This is No. 21 of Saunders' Question Compends, and for the class of book we consider it unusually good. Its bibliographical references are valuable, and the illustrations are well selected. It is too incomplete in its discussion of any disease to be taken as anything more than as a guide to the text-books to which reference is always given. J. W. P.

ESSENTIALS OF MEDICAL ELECTRICITY. By D. D. STEWART, M. D., Demonstrator of Diseases of the Nervous System, and Chief of the Neurological Clinic in the Jefferson Medical College, etc., and E. S. LAWRANCE, M. D., Chief of the Electrical Clinic and Assistant Demonstrator of Diseases of the Nervous System, in the Jefferson Medical College, etc. With sixty-five illustrations. Philadelphia: W. B. Saunders, 913 Walnut street. 1892.

This is No. 23 of the Question Compend series, and is written expressly for students. The book contains the usual illustrations of batteries, motor-points, electrodes, etc. There is one decided criticism which we wish to offer, and that is the lack of definiteness of the authors in speaking of the strength of currents and of the duration of time for a sitting. For instance, on page 148, we read that spasmodic wryneck should be treated by a current of moderate strength. A student does not know whether that means five, ten, or twenty milliamperes. No directions are given as to the number of minutes each sitting should last, nor as to the frequency of sittings. These are all important points, and should be mentioned just as certainly as we would direct the dose of a prescribed medicine and the frequency of taking it. The generalities of the book are good. J. W. P.

BOOKS AND PAMPHLETS RECEIVED.

Transactions of the American Gynecological Society. Volume XVI. For the year 1891. Philadelphia: Wm. J. Dornan, printer. 1891.

The Hydriatic Treatment of Typhoid Fever, according to Brand, Tripier, and Bouveret, and Volg. By Chr. Sihler, M. D., Ph. D., Professor of Histology in the Medical Department of the Western Reserve University, former Fellow of the Johns Hopkins University, and Assistant in the Biological Laboratory. Published by Chr. Sihler, 832 Scranton avenue, Cleveland, Ohio.

Essentials of Physics, arranged in the form of questions and answers. Prepared especially for Students of Medicine. By Fred J. Brockway, M. D., Assistant Demonstrator of Anatomy at the College of Physicians and Surgeons, New York. With 155 illustrations. Philadelphia: W. B Saunders, 913 Walnut street. 1892.

The Chinese, their Present and Future: Medical, Political, and Social. By Robert Coltman, Jr., M. D., Surgeon-in-Charge of the Presbyterian Hospital, at Teng Chow Fu; Consulting Physician of the American Southern Baptist Mission Society; Examiner in Surgery and Diseases of the Eye for the Shantung Medical Class; Consulting Physician to the English Baptist Mission, etc. Illustrated with fifteen fine photo-engravings. Philadelphia and London: F. A. Davis, publisher. 1891.

Stricture of the Rectum: A study of one hundred and thirty-eight cases. Second edition, enlarged. By Charles B. Kelsey, M. D., New York, Professor of Diseases of the Rectum at the New York Post-Graduate School and Hospital; late Professor of Rectal Surgery at the University of Vermont, etc., etc.

The Principles of Bacteriology: A Practical Manual for Students and Physicians. By A. C. Abbott, M. D., First Assistant, Laboratory of Hygiene, University of Pennsylvania, Philadelphia. With illustrations. Philadelphia: Lea Brothers & Co. 1892.

Addresses, Papers and Discussions in the Section of State Medicine, at the Forty-second Annual Meeting of the American Medical Association, at Washington, D. C., May 5-8, 1891. Chicago: Printed at the office of the Association. 1891.

Consumption: How to Prevent It and How to Live with It. Its Nature, its Causes, its Prevention, and the Mode of Life, Climate, Exercise, Food, Clothing, necessary for its cure. By N. S. Davis, Jr., A. M., M. D., Professor of the Principles and Practice of Medicine, Chicago Medical College; Physician to Mercy Hospital; Member of the American Medical Association, Illinois State Medical Society, Chicago Medical Society, Chicago Academy of Sciences, Illinois State Microscopical Society; Fellow of the American Academy of Medicine; author of a hand-book on Diseases of the Lungs, Heart and Kidneys. Philadelphia and London: F. A. Davis, publisher. 1891.

Syphilis in Ancient and Prehistoric Times. By Dr. F. Buret, Paris, France. Translated from the French with notes, by A. H. Ohmann-Dumesnil, M. D., Professor of Dermatology and Syphilology in the St. Louis College of Physicians and Surgeons; Consulting Dermatologist to the St. Louis City Hospital; Physician for Cutaneous Diseases to the

Alexian Brothers' Hospital; Dermatologist to St. Margaret's Hospital, etc., etc. Syphilis Today and Among the Ancients; in three volumes. Volume I., *Nihil sub sole novum*. Philadelphia and London: F. A. Davis, publisher. 1891.

Disease of the Bladder and Prostate. By Hal. C. Wyman, M. Sc., M. D., Professor of Surgery in the Michigan College of Medicine and Surgery, Detroit; Member of the American Medical Association, Michigan State Medical Society, Michigan Surgical and Pathological Society, Detroit Academy of Medicine; Surgeon Detroit Emergency Hospital, etc., etc. George S. Davis, Detroit, Mich. 1891.

Sleep, Insomnia, and Hypnotics. By E. P. Hurd, M. D., Member of the Massachusetts Medical Society; Member of the Climatological Society; Member of the Société de Medicine Pratique (Paris, France); one of the Physicians in the Anna Jaques Hospital, Newburyport, Mass. George S. Davis, Detroit, Mich. 1891.

A Manual of Operative Surgery. By Frederick Treves, F. R. C. S., Surgeon to, and Lecturer on Anatomy at the London Hospital. In two octavo volumes, containing 1550 pages, with 422 illustrations, mostly original. Per set, cloth, $9.00; leather, $11.00. Philadelphia: Lea Brothers & Co. 1892.

Surgical Diseases of the Ovaries and Fallopian Tubes, including Tubal Pregnancy. By J. Bland Sutton, F. R. C. S., Assistant Surgeon to the Middlesex Hospital, London; late Hunterian Professor, Royal College of Surgeons, of England. In one 12mo volume of 514 pages, with 119 engravings and five colored plates. Cloth, $3.00. Philadelphia: Lea Brothers & Co. 1892.

A Text-Book of Chemical Physiology and Pathology. By W. D. Halliburton, M. D., B. Sc., M. R. C. P., Professor of Physiology at King's College, London; Lecturer on Physiology at the London School of Medicine for Women; late Assistant Professor of Physiology at University College, London. With 104 illustrations. London: Longmans, Green & Co. New York: 15 East Sixteenth street. 1891.

Essentials of Medical Electricity. By D. D. Stewart, M. D., Demonstrator of Diseases of the Nervous System, and Chief of the Neurological Clinic, in the Jefferson Medical College; Physician to St. Mary's Hospital and to St. Christopher's Hospital for Children; Fellow of the College of Physicians of Philadelphia, etc.; and E. S. Lawrance, M. D., Chief of the Electrical Clinic and Assistant Demonstrator of Diseases of the Nervous System in the Jefferson Medical College; Physician to the Dispensary of St. Christopher's Hospital for Children, etc. With sixty-five illustrations. Philadelphia: W. B. Saunders, 913 Walnut street. 1892.

First Lines in Midwifery: A Guide to Attendance on Natural Labor for Medical Students and Midwives. By G. Ernest Herman, M. D., F. R. C. P., Obstetric Physician to the London Hospital, and Lecturer on Midwifery; Examiner in Midwifery to the Royal College of Surgeons. In one 12mo volume of 198 pages, with eighty illustrations. Cloth, $1.25. Students' Series of Manuals. Philadelphia: Lea Brothers & Co. 1892.

A Dictionary of Treatment, or Therapeutic Index, including Medical and Surgical Therapeutics. By William Whitla, M. D., Professor

of Materia Medica and Therapeutics in the Queen's College, Belfast. Revised and adapted to the Pharmacopeia of the United States. In one octavo volume of 917 pages. Cloth, $4.00. Philadelphia: Lea Brothers & Co. 1892.

Miscellany.

MR. HOWELLS' NEW WORK.—The announcement that Mr. Howells will leave *Harper's Magazine*, to take editorial charge of the *Cosmopolitan*, on March 1st, calls attention to the process of building up the staff of a great magazine. Probably in no monthly has the evolution been so distinctly under the eyes of the public as in the case of the *Cosmopolitan*. The first step after its editorial control was assumed by Mr. John Brisben Walker, was to add to it Edward Everett Hale, who took charge of a department called "Social Problems," subjects concerning which the greatest number of people are thinking today. Mr. Hale, who is a student, a fair-minded man, a thorough American, and a man of broad sympathies, has filled this position in a way to attract the attention not only of this country, but of leading European journals. Some months later, a department was established called "The Review of Current Events." To take charge of this, a man was needed who should be familiar not only with the great events of the past thirty years, but who knew personally the leading men of both the United States and Europe who could interpret motives and policies. Murat Halstead accepted this position with the distinct understanding that his monthly review should be philosophical and never partisan. The next step in the history of the *Cosmopolitan* was the placing of the review of the intellectual movement of the month in the hands of Mr. Brander Matthews, who for some time has been recognized as one of the two or three ablest critics in the United States.

Finally came the acceptance of the editorship conjointly with Mr. Walker, by Mr. William Dean Howells. Mr. Howells, who is recognized universally as the foremost American of letters, upon the expiration of this contract with Harper Brothers, on the first of March, will take in hand the destinies of a magazine which promises to exercise a share of influence with the reading classes of the United States. His entire services will be given to the *Cosmopolitan*, and everything he writes will appear in that magazine during the continuance of his editorship.

W. B. Saunders, publisher, of Philadelphia, announces the two following important works as being in the press :

"An American Text-book of Surgery," by Professors Keen, White, Burnett, Conner, Dennis, Park, Nancrede, Pilcher, Senn, Shepherd, Stimson, Thomson, and Warren. Forming one handsome royal octavo volume of about 1200 pages (10x7 inches), profusely illustrated with wood-cuts in text, and chromo-lithographic plates ; many of them engraved from original photographs and drawings furnished by the authors. Price, cloth, $7.00 ; sheep, $8.00.

"An American Text-book of the Theory and Practice of Medicine according to American Teachers," edited by Wm. Pepper, M. D., LL. D., Provost of the University of Pennsylvania. To be completed in two handsome royal octavo volumes of about 1000 pages each, with illustrations to elucidate the text wherever necessary. Price, per volume, cloth, $5.00 ; sheep, $6.00 ; half Russia, $7.00. For sale by subscription only.

Earache.—Take five parts of camphorated chloral, thirty parts of glycerine, and ten parts of oil of sweet almonds. A piece of cotton is saturated and introduced well into the ear, and it is also rubbed behind the ear. The pain is relieved as if by magic, and if there is inflammation it often subsides quickly.—*Medical Brief.*

The N. Y. Physicians' Mutual Aid Association now has one thousand members, composed only of regular physicians in good standing.

It assists needy members, aids widows of deceased members. Will pay $1,000 at death of a member as soon as the membership reaches 1,100.

Initiation fee is from $2.00 to $5.00, according to age, and no candidates are received over fifty years of age.

Opportunity is offered to join the association at any time by applying to Dr. W. G. Gregory or Dr. S. A. Dunham.

Notice to Contributors.—We are glad to receive contributions from every one who knows anything of interest to the profession. Articles designed for publication in the Journal should be handed in before the first day of the month. The Editors are not responsible for the views or opinions of contributors. All communications should be addressed to the Managing Editor, 284 Franklin St., Buffalo, N. Y.

Buffalo Medical and Surgical Journal

Vol. XXXI. APRIL, 1892. No. 9.

Original Communications.

REPORT OF A CASE OF DOUBLE DISLOCATION OF THE KNEE-JOINTS.

By THOMAS H. MANLEY, M. D.,
Visiting Surgeon to Harlem Hospital, New York.

In the city of Buffalo, Hamilton commenced those serial observations some years ago, which led to the publication of the first work printed in America on Fractures and Dislocations, and the most classical and complete exposition on the subject that had, up to that time, ever been written in the English language. As a matter of reverence to the memory of that great surgeon, and high regard for our brethren in the great western city, I have decided to offer something in the way of a report of a case of dislocation, to the Buffalo Medical and Surgical Journal, which, if it possesses no other value, it will deserve some merit, at least, in being, in many particulars, quite unique.

Besides reporting this singularly interesting case, I will take this opportunity to call the attention of physicians to a few features in connection with dislocations in general.

The subject of this report was:

A man thirty-three years old; medium height and build, who commonly enjoyed good health; he never had any serious malady, nor sustained severe injury before, being employed in a cabinet factory, running a planing machine. On the morning of October 2, 1891, while endeavoring to put his machine in motion, he was caught by the belt and carried with violent force over the shaft and pulley. The shaft was twenty-five feet from the floor, but the space between the over-hanging beams and the outer belt-surface of the pulley above was scarcely two feet. As his body was carried over the shaft, he struck the floor beams with terrible force, and was projected fifteen feet in a direction diagonally to the revolving shaft. It was at first supposed by his fellow-workers that he had been instantly killed, as he was completely motionless; bleeding

from the mouth, nose and wounds about the face. After a few minutes, however, he commenced to audibly gasp, when the ambulance was summoned.

Ambulance History.—Dr. Arch. Dixon, of the Harlem hospital house-staff, responded. His report of the case says: "That when the ambulance arrived, about twenty minutes after the accident, I saw the patient lying on his back in a state of profound collapse, the pulse being thready, very rapid and intermittent. The breathing was very shallow and sighing. His extremities were cold. There was a moderate drooling of blood from the mouth, while there was a free oozing from the right nostril. The bleeding from the mouth was attributable to slight abrasions, as there was no hemorrhagic expectoration from the lungs, nor was any blood raised in vomiting. He was perfectly conscious. There was no evidence of serious spinal injury, as there was no paralysis. Giving him whiskey by the mouth and digitaline by hypodermic injection, after a little while he so far recuperated that it was deemed safe to slightly shift his position, in order to make a superficial examination. As he lay flat on his back, it was evident, from the position of the toes, that there was joint or bone injury of the left leg, for the foot fell outwards and rested on its side, and the knee was slightly bent. On removing his coat it was found that he had a compound fracture of the right humerus close to the surgical neck, the inferior fragment protruding through the skin. On the same side of the body, at about the center of their shafts, the fifth, sixth, seventh and eighth ribs were fractured. After having had his trousers removed, it was evident that both knee-joints were dislocated. On the right side the condyles of the femur were displaced downward and forward, the head of the tibia rising high into the popliteal space, slightly adducted and rotated outward. There was no ecchymosis or extravasation into the cellular tissues. On the left side the dislocation was the reverse of the right with respect to the head of the femur, as here the condyles were displaced posterior to the head of the tibia, crowding down into the loose tissues of the popliteal space. The head of the tibia, owing to the manner in which it had risen into the capsule of the joint, had the articular surface of the patella lying flat across its horizontal surface. I was able to easily restore the joint surfaces to their proper relations on the right side, but the left dislocation required considerable manipulation and force before we succeeded. His knees were now, with the fractured arm, adjusted in splints, when he was placed in the ambulance and brought to the hospital."

Admission to Hospital.—Two hours after he was admitted into the male surgical ward I saw him. At this time he was yet in deep shock. His pulse was so feeble, and his integuments so blanched, that it seemed to me that he must be suffering from internal hemorrhage. The surface temperature was low, and his pulse was very feeble. His intellec-

tual faculties were undimmed, and he answered questions, though in feeble accents. He said he had no pain anywhere; that he had a numb, tingling feeling in the soles of both feet; that he felt cold, very weak, and thought he was dying. At this juncture all external hemorrhage had ceased. Regarding the injuries of a mortal character, he was not disturbed; but the nurses, nevertheless, were directed not to relax their efforts in endeavoring to arouse the ebbing vitals, and establish reaction. From his general condition it did not seem that he could survive more than a few hours. But he consumed hot whiskey freely, and, after having been covered on every side by artificial heat, after midnight he commenced to react, so that when I saw him again early the following morning, he was fairly restored, when a more critical examination of his injuries was made, in order to learn of their precise character, and institute such remedial measures as might be deemed most appropriate.

Before proceeding with a description of his condition, it may be well, for a moment, to consider the nature and extent of physical force brought into action in this case. We see, at the outset, that the violence sustained was inflicted mainly in three ways. First, he was instantaneously jerked from his feet with such suddenness as we might expect would wring a bone from its socket, or crush in a shaft. Secondly, he was shot through a narrow space, between the pulley and the rafters, with such force as one might suppose would scarcely leave a whole bone in his body—long bone. How he was carried through this narrow, irregular space without having a limb torn off, or an internal organ ruptured, is a mystery. Third, he was thrown with great force a considerable distance, striking on his right side against a machine, which was not, fortunately, in motion. So that we see that he was subjected to a triplicate force of great relative intensity, and hence, from a description of the manner in which the injuries were sustained, we might be prepared to find serious and multiple lesions.

On removing the bandages from the lower limbs, it was evident that the circulation below the femoro-tibial articulation was almost or completely arrested, as both legs and feet were cool, the left more than the right. No throb could be felt in either the posterior tibial, or dorsalis pedis, on either side. Besides, on surface pressure, the emptied capillaries failed to refill again. The ligaments, muscles, and tendons on the right side were so badly torn and stretched that it was found that if the heads of the bones were not fixed in contact with each other by some sort of a mechanical adjustment, the foot would fall on its side, and the tibial head

would rotate outward, the patella slipping inward and resting on its inner margin. The muscular and ligamentous disorganization on the left side was apparently not so extensive; for in their articulation the luxated bones remained in position without any tendency to spontaneous displacement.

At this time there was an extensive hemorrhagic effusion into the capsules of both knees, and ecchymotic straining of the integuments of the thighs, on their outer aspects from the major trochanter downward. Both limbs were now comfortably readjusted and artificial warmth maintained, with a view of preserving vitality and favoring the establishment of the circulation through the collateral channels. The principal articular and long sural arteries were now depended on to maintain vitality, for it was at this time quite clear that both popliteal trunks had suffered irreparable damage, and that all hope of saving the limbs depended on our ability to nourish the parts below by way of the subsidiary vessels. And this, it would seem, we would have accomplished had we the *vis a tergo*, the strong heart stroke, to pump the blood through the now narrowed portals. But our unfortunate man had his right thoracic chamber crushed in, the shivered costal shafts having evidently been driven deeply into the right pulmonary parenchyma, as the lung was now crowded far up under the superior ribs, and the pleura was filled with blood. Added to this there was an extensive emphysema into the cellular tissues of the lumbar, liver, and costo-spinal regions. The fracture of the humerus was of the oblique variety, with a tendency to adduction and rotation inward of the superior fragment by the infra- and supra-spinatus muscles. By firm padding of the axilla and forced flexion inward of the arm, this was fairly overcome, and the arm was fixed in a comfortable adjustment.

It is particularly interesting to note, in this connection, that notwithstanding the terrible injuries inflicted, the concussion, stretching, squeezing, and violent bruising which was sustained, the spinal-marrow wholly escaped, as did also the cerebral ganglia. He had perfect rectal and vesical control. There was no evidence of injury to any of the solid or hollow viscera of the abdomen.

Singular to say, in spite of the great force necessary to dissunder the powerful structures at both knee-joints, and cause the other serious injuries noted, this man rallied well, and had it not been for the consecutive events arising from disorganization of the popliteal vessels, he would have undoubtedly made a good recovery.

On the second day after admission, his general condition was very good. His temperature was under 100, and the pulse was 85, in the morning. There was but slight thirst. He had no chills, and there had been no vomiting. His arm was painful at the seat of fracture, and now that reaction was well established, there was considerable swelling in the loose connective tissues, external to the synovial investments of the knee-joints, which extended along the muscle planes to the groins. These areas were extremely sore and tender. At this time the left leg and foot presented an ominous aspect. From the knee down, the limb had a livid, bloated appearance, and there seemed an entire absence of circulation in the peripheral capillaries. The parts supplied mainly by the short saphenous, the muscular, cutaneous and anterior tibial nerves, were completely paralyzed. On the sole of the foot, along the parts vitalized by the internal and deep plantar branches, from the posterior tibial, the reflexes were yet intact, and normal sensation was but little dulled.

From the symptoms and signs, the rapid increase in volume in a limb almost devoid of circulation, it was rather suggestive of chemical changes, and the commencement of that process through which nature demands the return of the original elements, of which a part is physically constituted—of decomposition. Certainly, we might witness a rapid increase in the dimensions of a part by pathological processes, by cellular hyperplasia, edema, hemorrhage, etc., yet these are *vital* processes, and are only possible when the circulation is intact. As his general condition was now good, I ventured to recommend immediate amputation above the knee, but the patient demurred, and the family physician advised against it, at this stage. In the meantime, the limbs, from the toe nails up to above the knees, were kept thoroughly cleansed and swathed in antiseptic gauze. Gangrenous processes, however, went on, about the same as they always do under these circumstances.

On the morning of the third day unmistakable evidences of the total death of everything below the knee was evident, and gangrenous changes were rapidly advancing towards the trunk, so that it now became a question of disarticulation at the hip-joint. The cadaverous odor of the decomposing corporeal elements was widely diffused throughout the ward. The limb itself had become, in patches, charred, blackened and shrunken, the epithelium peeling off on the slightest rub, and now everywhere, below the knee, sensation was totally lost. As yet there was no evidence of pollution of the circulation through the absorption of the lethal elements of sphacelus.

On the afternoon of this day, after his consent had been reluctantly given, I amputated through the lower third of the femur. He rallied well from the operation, and, when the stump was dressed, two days after amputation, it was seen that there had been primary union along the entire seam of incision.

On the tenth day after admission, and the seventh after amputation, we were appalled to find evidence of peripheral gangrene, appearing in the right leg in brown, irregularly-formed plaques. Those patches looked as though the aqueous, albuminous, and fatty elements had been withdrawn from the involved integument, which gave it the appearance of the dried raw-hide of a drum-head. It was clear that while the circulation was not wholly shut off in this limb in the deeper structures, yet it was unmistakable that the surface structures were not amply nourished.

He positively refused to submit to an amputation of this limb, and, I think, wisely, for the infliction of another high amputation mutilation, on his already shattered anatomy, would, no doubt, have been more than he could endure. In this limb, as in its fellow, after the first appearance of gangrene, it rapidly ran into sphacelus, and reached the lower abdomen within forty-eight hours. He died on the nineteenth day after admission, from septic pneumonia.

For many important reasons it might seem proper that a case of this description should be reported in full. First, for its uniqueness. I can find no report of a case of *double* dislocation of the knees by any American author. Our principal authors on Dislocations, Hamilton[1] and Stimpson[2], do not tell us that they ever saw a case. Hamilton practically passes over the subject in silence, though Stimpson, in his book, citing from the French, mainly, mentions several cases which he was able to find. Among them there was one which occurred in the hospital service of Le Dentu, of La Pitié, in Paris. His man, like mine, was caught in a belt, dragged over a shaft, and sustained a double dislocation of both knee-joints, with the condyles of the femur occupying reversed positions, as in this case. It appears that this patient recovered with paralysis of one limb, and gangrene of the tendo-Achilles in the other.

Pathological Examination of the Amputated Limb.—As the incision into the soft parts, in this amputation of the limb, was car-

1. Hamilton, Fractures and Dislocations.
2. Stimpson, Fractures and Dislocations.

ried through a point above the joint, an opportunity was permitted us to examine the entire articulation and the morbid anatomy consequent on the injury. The tegumentary envelope had a bluish-black color throughout its entire extent. Between the cellular fascia and the skin, there was a dark, watery accumulation, of a foul odor. On dividing the thick fibrous aponeurosis of the leg, a large quantity of partly disorganized and coagulated blood escaped. This was very abundant in the popliteal space. The muscles and fibro-cellular elements were all deeply blood-stained. Between the muscle-sheaths in the direction of the long bones, gaseous decomposition was very general, so that on separating the muscles, there was a crepitating sound emitted from the inflated tissues.

Coming down to the great blood-trunks in the popliteal space, the popliteal artery was found completely thrombosed, from about half an inch below Hunter's canal, the coagulum extending into the anterior tibial and the first division of the posterior tibial. The peroneal, from this point downward, was pervious and empty. The internal coat of the artery, under the seat of the thrombus, was congested, thickened, and in places detached from the muscular coat; besides, there was a thin layer of organized lymph, easily detachable from the serosa. The cellular tunic of the vessel was greatly thickened, and, on microscopical examination, showed evidence of having sustained an extensive hemorrhagic extravasation, probably from the vasa-vasorum. The popliteal nerve, throughout its medulla, was softened, and in patches stained by foci of ecchymosis. Its neurilemma, however, was not torn.

The popliteal vein, at the point immediately below that at which the sural vessels enter, had been ruptured; but adhesive inflammation, in the over-lying tissues, had so approximated its divided walls, that there certainly was no leakage through it at the time of death. Its contents were of a black, tarry quality. The popliteal muscle was nearly completely torn off from its attachment into the outer condyle of the femur, and both heads of the gastrocnemii at their attachments showed evidences of extensive bruising and laceration.

Permission was refused us to dissect the other limb after death.

The report of the hospital pathologist on the complete microscopical examination is not received, or it would have been incorporated.

The untoward consequences to the extremities following these two luxations, forcibly present to us the direful results which may

occur after a dislocation in any of the articulations, particularly those of the extremities. This we can easily comprehend in the case of the knee, which, when dislocated, is acted upon by great force and compound motion ; for, to completely effect surface displacement here, we must have combined a violent bending, twisting, and extension force acting simultaneously. When this force is of sufficient velocity and intensity to dislodge the articular heads of bones, held in position by so many powerful tendons, muscles, and ligaments as we find at the knee-joint, we may always not only expect great shock from commotion of the whole body, but likewise extensive implication of the large nerve-trunks and blood-vessels, which, at the knee-joint particularly, are firmly held in position by an expansion of the fascia lata and tendons; and, besides, are in this situation the more immovably fixed by their divisions and subdivisions, which hold them down like so many roots, and make their abrupt displacement, without laceration or destructive contusion, scarcely possible. So that although we may, as in this case, succeed in prompt replacement of the luxated bones, yet the damage done to vital structures remains. Accordingly the great danger to life or limb is in those cases always of a consecutive character when no internal organ is implicated.

Stimpson,[1] in his unrivaled work on the subject of Dislocations, says: "That those complete dislocations at the knee derive their greatest importance from the grave consequences which so often arise from lesions of the blood-vessels, gangrene, paralysis," etc.

The great French surgeon,[2] Velpeau, was no less emphatic in his lessons on dislocations in general.

Although the quality of force is not always the same in dislocations as in fractures, yet, as a general rule, it may be said, a greater amount of force is necessary to dislocate a joint than to fracture a single shaft of bone. In these joints, the composition of which is principally ligamentous and tendinous, as the knee or ankle, a complete luxation is almost invariably followed by great limitation in motion and impairment of strength, to say nothing of the atrophy, wasting, or palsy, which may involve the parts beyond. The most common dislocation is that at the shoulder-joint. It is also the most harmless and easily remedied ; yet I have seen as many as ten shoulder-joint dislocations which were positively irreducible.

1. Stimpson on Dislocations, page 317.
2. Velpeau, Leçon Sur Les Dislocations.

I once saw a surgeon in Bellevue hospital, in the presence of the late Frank Hamilton, fracture the humerus in attempting to replace its head. On another occasion, at Charity Hospital, a famous surgeon, on joint surgery particularly, produced a large fleshy woman who had a luxated shoulder, in order to demonstrate how easily (?) those things were remedied when one only understood them. But after trying every conceivable method, and exhausting his own herculean strength, he utterly failed.

In the winter of 1884 I had two cases of irreducible shoulder-joint dislocations at the Work-house hospital, Blackwell's Island. Some of the visiting staff had seen them, and I brought over Dr. J. W. S. Gouley to assist me, but nothing could be done ; the bones remained unreduced. Having seen Schroder's method for reducing dislocated shoulders, its simplicity attracted me, and a physician having invited me in to reduce a dislocated shoulder, I employed this method. I had scarcely commenced to bring into action the full leverage which the plan affords, when the humeral shaft broke like a pipe stem. Prof. Dennis exhibited a case before the surgical section of the New York Academy of Medicine two years ago, of a boy who, after a dislocated shoulder, lost the use of his arm, which had to be amputated later. The great desideratum in the treatment of dislocations is to employ such force and direct it in such a manner as will favor the return of the displaced bones, without doing irreparable damage to the nerves, blood-vessels, or adjacent muscles producing a fracture ; otherwise it is much better to leave a limb unreduced in an obstinate case than to take chances on the employment of great force.

302 West Fifty-third Street.

The Prevalent Fashion of Self-Medication.—The writer has had frequent opportunities to observe the growing tendency, at the present day, among those wholly unacquainted with the action of medicines, to the self-administration of the most powerful remedies. Surely, never before these advanced days, has it been customary for men and women to prescribe for their own use, without consultation with medical men as to the properties of the case, medicines which, in large doses, are dangerous, even to a toxical degree. Should there not be some restriction upon the sale by pharmacists of many of these potent agents, not in the interest of the medical profession, but in that of the venturesome experimenters themselves, whose lives are often jeopardized by such injudicious self-medication?—*Editorial in College and Clinical Record.*

Clinical Reports.

SUB-ACUTE PARENCHYMATOUS HEPATITIS AND GASTRO-ENTERITIS.[1]

By A. L. BENEDICT, A. M., M. D.

On December 17, 1891, I was called to see Mr. M., a bartender, aged twenty-eight; large framed and muscularly strong, yet giving one the impression of a person of weak will-power, easily controlled by appetite and deficient in visceral innervation. Three or four days previously the patient had been attacked with painful diarrhea and vomiting, for which he had received treatment without much result, except that the opiate in his medicine had temporarily controlled his pain, and afterward increased the nausea and general distress. Questioned with regard to his habits, the patient said he was temperate, but his notion of temperance was found to mean the use of four or five glasses of strong liquor daily, with an occasional spree. A little over-indulgence in alcoholics, combined with bad food, had precipitated this attack, to which his habits and lithemic condition predisposed.

On physical examination nothing was found wrong except a slight pharyngitis and the condition of the abdominal viscera. The stomach was distended with gas; the liver enlarged downward about three-quarters of an inch, and tender; there was quite uniform gaseous distension of the intestines, with moderate tenderness. At one point in the right hypochondrium, about four inches obliquely upward and to the right from the umbilicus, there was a small area of excessive tenderness, in which palpation detected a soft elevated something, apparently either a loop of intestine, or possibly part of an enlarged gall-bladder. There was moderate fever, the tongue was coated; the discharge from the bowels was offensive, consisting of soft, mud-colored lumps in dirty liquid. The urine was dark, depositing urates, but without albumin, casts or sugar. There was a slight sallowness, not amounting to jaundice.

The diagnosis was made of subacute parenchymatous hepatitis, gastro-enteritis, and possibly gall-stones. With regard to the condition of the liver, many would probably prefer to regard it as congestion. The existence of gall-stones was conjectural; none were found, and the passages of the first few days had already been thrown away. None of the later symptoms were significant in regard to this point.

Small doses of tincture of belladonna, fluid extract of cannabis

1. Read before the Buffalo Clinical Society.

indica, and carbolic acid were given through the afternoon and night, and the next day the patient was placed upon powders containing fifty centigrams each of salol and bismuth sub-carbonate, repeated every four hours. He was more than willing to accept my proposition to do away with opiates, although two or three nights later he took a quarter of a grain of morphine. The former physician-in-charge had prescribed a liniment containing a moderate amount of tincture of opium, and this I continued through the first night, partly on account of the relief of pain afforded,—an action mainly local, though to a considerable extent central, even when opium is used externally, but largely because I make it a rule, in taking charge of a case which has been under the care of another physician, to continue, at least, some item of his treatment. There is a very widespread impression among the laity that a change of physicians means an entire upsetting of former methods of medication, and some members of the profession, unfortunately, are small enough to try to make capital for themselves by means of more or less open slurs upon the man whom they succeed. Leaving out of consideration the golden rule and the code of professional courtesy, the man who, by his speech and action, shows respect for his fellow-practitioners, not only raises the estimation of the whole medical profession in the minds of the laity, but gains for himself more credit than by insinuation or open criticism.

With reference to the treatment, carbolic acid is not an efficient antiseptic, either for internal or external use, unless its dose or strength be dangerous. It is, however, a good, though mild anesthetic, and by means of its slight antiseptic power it is especially indicated in painful conditions of the stomach with fermentation. Belladonna is also locally anesthetic, and it depresses the activity of involuntary muscle; hence its usefulness in painful affections of the stomach and bowel associated with excessive peristalsis. It would also have facilitated the passage of a gall-stone, had one been present. Cannabis indica acts in almost the same way as belladonna, although somewhat more mildly. Hence it may be used independently of, or auxiliary to, belladonna without danger of accumulating excessive amounts of atropine in the body. Cannabis indica has often proved disappointing, partly because too much has been expected of it, partly because too small doses have been given, partly because poor preparations have been used. In colicky conditions of the bowels, I like to use some form of menthol,—for example, the essence of peppermint. This particular patient

objected to the taste of peppermint, and it was, therefore, not used. Bismuth subcarbonate is preferable to the subnitrate, because when decomposed a very weak acid gas, carbon dioxide, is evolved instead of the more active nitric residue. The difference, however, is more theoretical than practical.

Two days after my first visit, I introduced the stomach tube and washed out the stomach. This procedure caused extreme gagging and discomfort, but it was efficient in removing a considerable accumulation of mucus, bile and undigested food. For the first two or three days, almost no food except toast water was given. Later, broths, milk and bovinine were ordered. The patient was convalescent in four days and two days later he was discharged perfectly well, except for some slight weakness. On account of the patient's lithemic condition, it is quite probable that if his habits are indulged in, he will develop cirrhosis of the liver or kidneys, or perhaps of both. I have, therefore, advised him most earnestly to give up entirely the use of alcoholics.

Society Proceedings.

NEW YORK ACADEMY OF MEDICINE.—SECTION ON ORTHOPEDIC SURGERY.

Stated Meeting, February 19, 1892.

HENRY LING TAYLOR, M. D., Chairman.

Dr. W. R. TOWNSEND presented a girl, fourteen years of age, with rotary lateral curvature. At the age of three years, and after whooping cough, she developed an empyema on the left side, which opened spontaneously. These sinuses continued to discharge for five years, and the three cicatrices, one to the left of the nipple, and two slightly below and to the right, show the points where the openings occurred. When five years old, it was noticed one morning that there was a complete loss of power in the left upper extremity. The mother said that there had never been any curvature of the spine before the attack of paralysis, although the child always slept on the left side, and that the curvature has been steadily increasing since then. The circumference of the chest at the nipples is twenty-four inches, the right side measuring fifteen, and the left nine inches. There is a very marked lateral

rotary deviation of the spinal column to the right, extending from the seventh cervical to the tenth dorsal, with compensating curves above and below. There is no torticollis. The breathing space is good, considering the amount of the deformity. The heart is not displaced. There is complete loss of reaction to faradism in the left supra- and infraspinatus, and in the deltoid, and a reversal of the formula with the galvanic current. There is no anesthesia, but marked atrophy of the shoulder and upper left arm. There is a partial loss of reaction in the pectoral, but the biceps, triceps, and forearm muscles react well.

The interesting feature was the relation of the rotary curvature to the empyema and the poliomyelitis. His own opinion was that the empyema probably caused a slight curvature, and that the paralysis had helped to increase it, but that there was no connection between the empyema and the paralysis; in other words, the paralysis was not produced by the scoliosis, but was separate and distinct, and due to a poliomyelitis. He had presented the case chiefly because it was of interest in connection with the first paper announced for the evening.

Dr. Royal Whitman also presented a little girl as an illustration of a pure rotary lateral curvature, caused by anterior poliomyelitis.

Dr. H. W. Berg said that he had had an opportunity of seeing this patient, and had obtained a somewhat different history. According to this version, the patient was still in bed with the empyema, when the family first noticed that she was lying more upon the left side. The occurrence of the paralysis was sudden, and the attending physician allowed her to get out of bed, and at this time the extreme lateral curvature was first noticed. If this curvature were the result of the poliomyelitis, it would not have been so extreme at this early stage, for it takes time for muscles to contract and cause deformity. In this case the paralyzed muscles are on the left side of the body, and the primary curve toward the right, while in cases of lateral curvature due to paralysis, the healthy muscles must necessarily be on the concave side of the deformity. The only way in which poliomyelitis could possibly produce a curvature on the concave side of the deformity, would be in the third stage of this disease, *i. e.*, in the third or fourth year after the paralysis, when the muscles begin to contract into firm fibrous cords.

Dr. Royal Whitman thought if the long supporting muscles were paralyzed, it might be as the previous speaker had said, but

in those cases where only the muscles supplying the shoulder were paralyzed, one would expect the curvature to be toward the opposite side.

Dr. Berg replied that the intrinsic muscles are not alone paralyzed in this case. Lateral curvature must follow contraction of the intrinsic muscles of the spine, and not of the long muscles.

Dr. R. H. Sayre had seen a number of cases of lateral curvature dependent upon poliomyelitis with paralysis of the external muscles on the concave side, and hence, he thought, the statement that the convexity is always on the side of the paralyzed muscles could not be accepted without qualification. He had been surprised that German writers took it for granted that empyema curves are not rotary.

Dr. S. Ketch was not prepared to endorse the view that the curvature was mainly due to the empyema; on the contrary, he thought the patient had that form of curvature usually found as a result of anterior poliomyelitis. Undoubtedly the empyema tended to exaggerate this curvature.

Dr. N. M. Shaffer said that, so far as he knew, the first reported case of lateral curvature due to poliomyelitis had been published in his book in 1876 or 1878. That case had been examined by Dr. Seguin, Dr. Draper, and himself, and they had found the paralysis on the hollow side. On general principles, he believed that Dr. Berg was correct in his statement. In 1881, he had called attention to the fact that a rotary element existed in empyemic curves. It was exceptional for him to find a lateral curvature of the spine, due to empyema, which was not associated with a greater or less degree of rotation. The error probably arose from the fact that Dr. W. J. Little, of London, who first described it, made this mistake, and other writers had perpetuated the error.

Dr. Mary Putnam Jacobi called attention to the monograph by Fulenberg, on lateral curvature of the spine, in which he stated very categorically, that in ordinary typical cases of lateral curvature, the muscles on the concave side are necessarily the stronger, and explains on this principle the mechanism of the production of lateral curvature. His idea is, that it is due to a disturbance in the balance of the muscles of the two sides, whether extrinsic or intrinsic.

Dr. A. B. Judson said that in his earlier studies of lateral curvature, he had adopted, without due verification, the statement of

foreign observers that rotation is absent from the curvature caused by pleural disease. At present, he believed that it does not occur, but in a very modified and unimportant degree. The collapse of the chest wall would weaken the action of some of the muscular and fibrous structures which cause rotation by holding the spinous processes nearer the median line than the bodies of the vertebræ. For this reason we may well expect the rotation to be less marked. In the case shown, there is little difference in the diagonal diameters, which is the chief feature of rotation, and is caused, in an ordinary case, by the prominence posteriorly of the right back of the chest, and the complementary prominence anteriorly of the left front of the chest. Here we have prominence, front and back, on the right side, and depression, front and back, on the left side, with but little difference in the diagonal diameters, a condition very unlike the effect of rotation. Still there may be, and probably is, some rotation in the vertebral column of this patient, although its effect on the deformity is not easily recognizable.

Dr. Townsend said that, owing to the fact that in this case one was compelled to rely wholly upon the varying statements of the parents of the child, who were not very close observers, it would be well to be cautious in drawing conclusions from a study of this case alone. He did not agree with Dr. Berg as to the relation of the paralyzed muscles to the concave side.

VOLUNTARY SUBLUXATION OF THE KNEE PRODUCED BY MUSCULAR ACTION.

Dr. R. H. Sayre showed a child of fourteen months, presenting this condition. The mother first noticed this condition when the child was eight months old. When he was excited, the right knee is pushed in and out with a distinct click. The child was born after a normal labor, and there was no history of injury. He proposed to apply a splint, in order to retain the knee in position.

AN APPLIANCE FOR THE PREVENTION OF DEFORMITY IN HIP DISEASE.

Dr. Whitman presented a case illustrating this appliance. He believed that the long traction brace was the most useful appliance in these cases, for it assured, as a perineal crutch, a protection which could not be removed by the patient. This was the principal objection to any brace which depended on axillary crutches

for its usefulness. Simple fixation of the joint, allowing the patient to walk about on the affected limb, as practised by Thomas and others, did not afford this protection, which he considered the most important element in the treatment of any joint affection. On the other hand, with the simple long traction brace, gradual and increasing flexion of the leg was a very common and troublesome complication. This was the weak point of the brace, and the one most constantly attacked by its opponents. He had therefore attempted to combine the merits of two braces as follows: The limb having been brought into perfect position, a slender steel bar attached above to an encircling thoracic band, and terminating just above the knee in a thigh band, was closely applied along the posterior aspect of the joint, after the manner of Thomas. The long traction brace was then applied as usual. Thus flexion was prevented, additional fixation assured, combined with effective protection. By dividing the function of the two braces, the posterior or miniature Thomas brace could be made very light and comfortable; it, however, was not to be used as a lever to correct deformity. This should first be overcome by traction in bed or otherwise. He believed this division of labor to be more practicable than the addition of perineal bands and traction to the ordinary Thomas brace, as suggested by Lovett and De Pass.

Dr. Judson commended the use of one apparatus, the hip splint, to protect the joint, and another, the antero-posterior lever, if apparatus is necessary for this purpose, to oppose flexion. In general, it is better not to attempt too many things by one and the same apparatus. He thought the antero-posterior lever, for combating flexion and maintaining fixation, was the essential element of the Thomas splint.

Dr. Shaffer said that where supplementary apparatus is employed to limit the motion of the dorso-lumbar spine and the motion on the acetabulum, unnecessary traumatism was inflicted upon the acetabulum. He had studied the subject quite closely, and, in his opinion, this motion of the dorso-lumbar spine is one of the greatest aids in the treatment of this condition. It was better to treat flexion by recumbency and rest until the flexion is overcome, than to apply an apparatus which antagonizes the very strong action of the flexor muscles.

Dr. Whitman said he recognized the force of what Dr. Shaffer had said about the flexibility of the lumbar spine, but he was inclined to think that the motion of the diseased joint which the

simple traction brace permitted, and the deformity which it did not prevent, were more important considerations than the theoretical objection which Dr. Shaffer had presented. This fixation apparatus was applied before there was any flexion, and in the case presented there was no spasm of any of the muscles.

DOES SCOLIOSIS EVER GIVE RISE TO PRESSURE MYELITIS?

Dr. H. W. Berg read a paper with the above title.

DISCUSSION.

Dr. H. R. Sayre thought there was no doubt that the differences in mammary development observed in cases of rotary lateral curvature were the result of trophic change, but the cause of this disturbance was still uncertain. In advanced cases, he had been inclined to attribute this disturbance to pressure on the nerves at their exit from the bony canal. Pathological specimens showed not only a narrowing of the bony canal, but also large exostoses at the points where the vertebræ join; it was quite possible that these might project inward as well as outward.

The case described in the paper had at one time been under his care, and he had considered it as closely resembling disseminated sclerosis, although it was not typical of any diseased condition with which he was familiar. Dr. Spitzka had held the same position. The case had been diagnosticated as lateral sclerosis by one neurologist, and as hysteria by another eminent neurologist, who had employed hypnotism upon the patient, though unsuccessfully. She had been referred to the speaker with the idea that there was some pressure on the cord at about the tenth dorsal vertebra, which might possibly be relieved by a surgical operation. He had been unable, however, to detect any mass pressing upon the cord, and from the effects of momentary suspension, he did not think this method of treatment would prove beneficial. He did not associate the cord lesion with the lateral curvature. The trophic changes were probably due to disturbances of nutrition external to the cord.

Dr. Shaffer considered that the author's case of lateral curvature differed only in degree from almost every case of this condition. It was rare to find lateral curvature without an exaggerated tendon reflex, a non-deforming club-foot, or various trophic changes, and the latter occur in incipient cases, before there can be any pressure on the cord. Girls suffering from lateral curvature are usually

peculiarly nervous, and oftentimes seem to assume the responsibilities of their entire families. This is the direct result of the central nervous lesion, one which pertains more to the psychical condition than to the spinal cord condition. Our clinical studies drive us by analogy to look in the motor tract of the brain for the cause of the condition.

Dr. KETCH looked upon the trophic changes as an element in the etiology of lateral curvature, rather than the result of this condition. It was probable that at a very early period in life there was a disturbance of the nervous system, most probably of the brain, which produced the lateral curvature. Boys having lateral curvature, show atrophy of the limbs, but the general nervousness is not so marked. For example, he had at present under observation, a robust boy, fifteen years old, with lateral curvature, who was supernaturally strong and supernaturally slow and apathetic. He thought it highly improbable that pressure myelitis ever occurred in these cases.

Dr. L. W. HUBBARD could not understand how the paraplegia of Pott's disease could be said to be due to cord pressure from change of position, as clinically it seemed to bear no relation to the amount of curvature, or to the situation of the lesion, and it was present when there was no curvature ; and, moreover, recovery took place without any change in the curve of the spine. He saw nothing in the case reported analogous to the myelitis of Pott's disease.

Dr. JUDSON would eliminate muscular contraction as a factor in the causation of lateral curvature, believing that rotation and the curvatures, primary and secondary, are only the mechanical result of muscular failure to sustain the weight of the trunk. He would welcome with extreme pleasure any advance in our exact knowledge of the etiology of lateral curvature.

Dr. V. P. GIBNEY had never seen pressure myelitis in an uncomplicated case of rotary lateral curvature.

The CHAIRMAN agreed with Dr. Hubbard, that the analogy of the case under discussion to the myelitis of Pott's disease was not very strong, as, according to the view advanced by Dr. Hoffa at the last meeting of the American Orthopedic Association, and generally accepted by those present, the paraplegia is due to the pressure of inflammatory products. Personally, he had never seen a case of lateral curvature complicated by paraplegia or symptoms of lateral

sclerosis. Last Fall he had had a case of very moderate curvature with a very peculiar ataxic gait, but a careful examination excluded organic disease of the spinal cord, and it was decided to be a case of functional nervous disturbance, possibly produced by masturbation. It seemed strange that such a mild case as the one described in the paper should produce such marked nervous symptoms, while the much more severe cases so often seen have no analogous symptoms. He looked upon the cord lesion as merely a coincidence.

Dr. Berg, in closing the discussion, said that he thought the diagnosis of disseminated sclerosis very improbable, and this diagnosis had probably been made because a primary sclerosis of the cord is such a rare condition that whenever a neurologist sees a spastic paralysis in an adult, and can find no cerebral symptoms, or symptoms of pressure upon the cord, he makes a diagnosis of dis seminated sclerosis. S. Weir Mitchell had given it as his opinion, that the case was one of primary lateral sclerosis. There was no doubt as to the sclerosis and the lateral curvature, the only doubt is as to the connection between the lateral curvature : and the sclerosis. Pott's paraplegia is caused by a variety of conditions, but he believed that in nearly seventy-five per cent. of the cases, the paraplegia was due to pressure resulting from flexion of the cord at the angle of the curve. He had no doubt that hundreds of cases had been seen where the lateral curvature had been considered the result of paralysis, where it was really the cause.

FEMORAL ADDUCTION, ABDUCTION AND FLEXION.

Dr. Judson presented a convenient method of observing the degrees of motion in cured and convalescing cases of hip disease. The subject was illustrated by boards on which dolls were fixed, the center of motion at the hip in each case being surrounded by a graduated arc with the degrees numbered from zero, in the natural position of supine recumbency, with a slight lordosis, up to the widest limit of normal motion. In practice, the region of motion is first to be found, and then the extent to which it may be pushed, without disturbing the natural and symmetrical position of the lumbar vertebræ and the iliac spines, is to be noted on the goniometer. The degrees of motion in flexion and laterally may thus be readily recorded.

The presence of considerable motion warrants a serious effort

to reduce whatever deformity may exist. He cited two cases in which the patients being considered cured, relief had been sought for the deformity. Enough motion was found to encourage hope, and good results were recorded in a few months in each case after the application of a hip splint, and later, a simple ischiatic crutch, and the return of the patient by instruction and drill to the natural rhythm of walking. The improvement was readily measured in degrees from time to time, and the deformity was almost completely reduced.

A NEW METHOD OF MAKING PLASTER CASTS OF THE THORAX IN CASES OF ROTARY LATERAL CURVATURE.

Dr. MARY PUTNAM JACOBI exhibited a series of models which she had prepared by an original method. It had been suggested to her by observations made with the crytometer upon the condition of the thorax after empyema. An outline of the thorax at the desired level is first taken with a crytometer, which is an instrument consisting of two soft strips of lead united by a hinge, which is placed over the vertebral column, and the lead strips closely applied to the chest walls. The lead is next placed upon a slab of marble, where it serves as a sort of shallow frame, into which the plaster of Paris cream is poured, and allowed to set. This gives practically a thin plaster cast representing a section of the thorax.

She called attention to the ease with which the diagonal diameter could be obtained, and also to the way in which these casts brought out small degrees of curvature.

Discussion on the papers of Drs. Judson and Jacobi postponed.

MEDICAL SOCIETY OF THE COUNTY OF ERIE.

Reported by ELI H. LONG, M. D., Secretary.

Special Meeting held in the Y. M. C. A. Building, Feb. 20, 1892.

THE President, WILLIAM WARREN POTTER, M. D., in the Chair.

The meeting was called to order at 8.30 P. M., and the President stated the object of the meeting, which had been called at the request of five members, to take action with reference to the Bill pending in the State Legislature providing an amendment to the Medical Examiners' Law of 1890, exempting certain students from its operations. He gave a résumé of the origin of the movement

for State license and the struggles to obtain the law, and stated that it was now in a fair way to be rendered useless, for a time at least, if the amendments prevailed that were now proposed and advocated by the students of the classes of '93 in the several medical colleges, with the exception of that of Niagara University, which had pronounced against it in unmistakable terms.

Dr. CHARLES CARY moved that a committee of three be appointed by the chair to formulate a suitable expression of the opinion of the society on the subject. Drs. Charles Cary, Thomas Lothrop, and Edward Storck were appointed a committee in accordance with these instructions of the society, and after deliberation reported the following:

WHEREAS, The Medical Society of the County of Erie is, and has been from the earliest agitation of the subject, in favor of a separate State Examining and Licensing Board; and,

WHEREAS, This society took the initial action which led to the passage of the present law (Chapter 507, Laws of 1890,) on this subject; and,

WHEREAS, This society has heretofore, namely, on the 20th of March, 1891, expressed its opposition to any amendments of the law until it should be thoroughly tested; and,

WHEREAS, This society has heard that a bill for the exemption of students who matriculated in medical colleges prior to December 1, 1891, has already passed the Senate; and,

WHEREAS, This society has also learned that the same or a similar bill is now pending in the Assembly, known as Assembly bill No. 513; and,

WHEREAS, This society deems the passage of such a measure as directly prejudicial to the public interests of the State, in that it delays an attempt to improve the public health service, which was sought to be benefitted by giving to the people better educated and more amply equipped physicians; and,

WHEREAS, The faculties of the University of Buffalo and the Niagara University, the only medical teaching faculties in Western New York, are members of this society, and as such members in their individual capacity, as well as in their official relations to their respective medical colleges, are absolutely and unqualifiedly opposed to any amendments at present to the law in question; therefore,

Resolved, That we, the members of the Medical Society of the County of Erie, in special session assembled, do hereby request the Senator and Members of the Assembly from Erie county to use all honorable means to defeat any legislation which may have been presented, or which may hereafter be offered in either house of the Legislature, looking toward any

change or modification in Chapter 507 of the Laws of 1890 as it now stands; and particularly do we request each and every one of our representatives in the State Legislature of 1892 to use their utmost endeavors to prevent the passage of the Bill referred to, now understood to be resting with the Committee on Public Health in the Assembly, and known as Assembly Bill No. 513.

CHARLES CARY,
THOMAS LOTHROP,
E. STORCK,
Committee.

After remarks by Drs. Cary, Lothrop, Hopkins, Storck, Clark, Mynter, and others, the preamble and resolution were adopted without dissent.

Dr. HENRY R. HOPKINS then offered the following memorial, which was approved by the society and ordered to be transmitted to the Assembly, signed by the President and the Secretary:

To the Assembly:

The Medical Society of the County of Erie, in special session convened, on the 20th day of February, 1892, respectfully petitions your honorable body to reject Assembly Bill 513, which provides certain amendments to Chapter 507 of the Laws of 1890, for the following reasons:

First. – Because the law referred to (Chapter 507, Laws of 1890,) is a beneficient measure, framed and enacted in the interest of the public, to promote public health, and to prevent unqualified men from exercising the functions of physicians.

Second. – Because it is a wise law, one in accordance with the spirit of the age, is in keeping with similar statutes prevailing in other States on the subject of separate licenses for physicians, and has been used as a model in many of the States. We are informed that some twenty-four States now provide that physicians shall not practise within their borders without a State license.

Third. – Because the law was passed after considerate and prolonged discussion and argument, not only among medical men, but by the public in general and through the newspaper press in particular, and it did not take effect until some fifteen months after it had received the sanction of the executive. It was signed June 5, 1890, to go into operation September 1, 1891.

Fourth. – Because already such students as have matriculated in the medical colleges in this State prior to June 5, 1890, have been exempted

from the provisions of the law by a special act which amended it to that effect, passed last year.

Fifth.—Because we feel that it is prejudicial to the public welfare, in opposition to the spirit of the law, and against right, justice, and good government, to grant any further exemption, or to amend the existing statute in any particular, until it has been tested by at least a year's trial in its application to the graduates of colleges in the State of New York.

Sixth.—At present only those physicians who have received diplomas granted from without the borders of the State of New York are amenable to the provisions of the law, and we believe it unjust to compel the citizens of other States to undergo State examinations that are not also required of the citizens of the State of New York. Discrimination of this sort against the citizens of other States has always been considered contrary to the spirit of our fundamental law, and certainly was not the intent of the framers of the existing law on the subject of State examinations for State licenses.

Seventh. – For these and other reasons which might be named almost *ad infinitum*, but which we forbear to enumerate lest we needlessly take up too much of your valuable time, we pray you, in all earnestness, to grant our petition.

Dated at Buffalo, February 20, 1892.

For the Medical Society of the County of Erie.

(Signed), WILLIAM WARREN POTTER, *President*.

Attest: ELI H. LONG, *Secretary*.

On motion of Dr. Edward Clark, a committee of three, one of which shall be the President, and the other two to be appointed by the chair, was directed to proceed to Albany, and present the views of the Medical Society of the County of Erie to the Committee on Public Health, in opposition to Assembly Bill 513, known as the Students' Exemption Bill. The chair appointed as members of that committee, Dr. Edward Clark and Dr. Thomas Lothrop, but the latter having declined to serve by reason of professional engagements, Dr. Ernest Wende was substituted in his place.

Dr. HOPKINS moved that the Secretary address a circular to the several county medical societies throughout the State, inclosing the official proceedings of the society on this subject, and asking their coöperation to prevent the passage of the bill in question. After some remarks suggesting methods of procedure by several members, the motion was adopted without division.

The society then adjourned.

SECOND SPECIAL MEETING.

Reported by DELANCEY ROCHESTER, M. D., Secretary *pro tem.*

A special meeting of the Medical Society of the County of Erie was held at its hall, in the Y. M. C. A. Building, Monday, February 29, 1892, to take action with reference to the death of Dr. John D. Hill.

The President, William Warren Potter, M. D., called the meeting to order at 8.45 P. M., in a few remarks with reference to the life and character of the deceased. In the absence of the Secretary, Dr. DeLancey Rochester was appointed Secretary *pro tem.*

On motion of Dr. Thomas Lothrop, seconded by Dr. H. R. Hopkins, a committee of three was appointed by the chair to prepare a memorial expressive of the sentiments of the society with reference to the deceased. The chair appointed as members of this committee, Drs. Thomas Lothrop, F. W. Bartlett, and H. R. Hopkins. After deliberation the committee reported the following:

MEMORIAL.

JOHN DAVIDSON HILL, M. D.,

Ex-President of the Medical Society of the County of Erie, Died Feb. 27, 1892, Aged 70 years.

This society is called together in special meeting to record its deep sense of sorrow in view of the death of another of its oldest and most honored members. The subject of this memorial has been identified with the professional and eleemosynary interests of this city from his early manhood, and has at all times commanded the respect and confidence of his fellow-citizens for his eminent ability, his superior administrative qualities, and the energy and independence of his character.

The distinguishing feature of his life has been portrayed in his strong personality; he possessed a wide and matured experience, rare judgment in practical medicine, and skill in his profession, which commanded a large and lucrative practice among the most substantial and intelligent members of the community.

He was thoroughly self-reliant, and his judgment at the bedside, his fertility of resource, his untiring devotion to his patients, as well as his self-sacrificing labors in their behalf, were sources of strength which have been recognized and appreciated among his friends and patrons.

He was universally respected as an upright citizen, a sagacious financier, a devotee to the highest moral and religious interests of the community in which he lived, and who gave according to his means and opportunity to the advancement of the varied interests of the city of his adoption, for which he entertained a commendable pride.

Failing to recognize the fact that increasing years bring a decrease of physical vigor which his professional experience and perception detected in others, he devoted to his practice, even after passing the meridian of life, the same tireless energy and self-sacrificing labor which were required of him in the full vigor of his manhood. Exhausted strength failed to find adequate recuperative powers, and he awakened to the reality, too late to correct the mistake which became apparent to him, that his physical forces were undermined, and fatal disease had gained the mastery over the robust and vigorous organization which had stood him well in hand in the activities of mature manhood. Prolonged rest and travel in foreign lands failed to bring back the vigor and ambition of youth. Calmly estimating the factors in the problem of life, he realized the inevitable result of the morbific changes going on in his system, and bravely awaited the fulfilment of the inevitable law which consigns his body to mother earth and his soul to its eternal rest.

Finally, it is resolved that this Society attend the funeral of our deceased brother, and a copy of this memorial be transmitted to his family.

THOMAS LOTHROP,
F. W. BARTLETT,
H. R. HOPKINS.

Remarks were made in support of the memorial and eulogistic of the life and character of Dr. Hill by Drs. Thomas Lothrop, Lucien Howe, F. W. Bartlett, H. E. Hayd, H. R. Hopkins, and C. A. Ring.

Dr. J. B. ANDREWS submitted the following in writing:

I desire to make a few remarks upon the memorial which has been presented to the society regarding the death of Dr. John D. Hill. It has been my good fortune to know the doctor intimately for the past twelve years, during which time he has been a member of the Board of Managers of the Buffalo State Hospital; this acquaintance ripened into deep friendship, that gave me an insight into his life and character, which, perhaps, has fallen to the lot of but few here present. The knowledge of what he has done for the charities of the State and the city of Buffalo, was a revelation to me of the possession by him of the most admirable and lovable traits. He was a faithful friend and safe counselor, easily approached, always positive in his convictions and most earnest in their advocacy. Of his professional career, there are others here who have a better knowledge. His early professional life proved him to be a man who could depart from the routine of practice, and showed he had the courage to put in force his own views of treatment. To his patients he was something more than a physician,—he became to them a friend, and often stood in the place of a father. The families which he served became closely attached to him, and remained so until

his last illness and death. His business ability was of a marked kind; he could intuitively see and appreciate any subject that was presented for his consideration. In overseeing the affairs of the institution, he had the same regard for economy, and the same zealous care of all its concerns that he had for his own personal interests. The patients at the hospital became much attached to him from his kind and gentle manners, and for the care which he exhibited for them; to the officers and employees he was always kind and courteous, and to them all his death is a personal loss. In his life he gave an example of the Christian physician, which cannot fail to make its impression upon all with whom he was associated.

The report of the committee was unanimously adopted by a rising vote.

The society then adjourned.

OBSTETRIC CALENDAR.

Dr. Lingrand, *Le Concours Méd.*, gives the following table which will be found very convenient for making calculations, especially as it can be very readily learned:

Jan 3	May 6	Sept..... 3
Feb 3	June 3	Oct..... 3
March..... 5	July 4	Nov..... 3
April..... 5	Aug..... 3	Dec..... 4

To arrive at the 270 days, start at the day which marks the end of menstruation and count backwards three months, then subtract the number of days indicated in the table opposite the month in which the catamenia ceased. For example, the 24th of July being the day indicated above, we begin by counting backwards: June 24, May 24, April 24—April 24 less four days (the number opposite the month of July in the table)=April 20=270 days. To this may be added seven days, or better, from seven to seventeen days according as the fetal movements first perceived by the mother indicate a period more or less near the last day of menstruation.

Where February has twenty-nine days, as in the present year, and is included in the calculation, one day more should be subtracted.—*Medical Abstract.*

The physician who values his time and advice is the man who is appreciated.—*Ex.*

He who sells himself for nothing generally gets all he is worth.—*Ex.*

Progress in Medical Science.

THERAPEUTIC NOTES.

For forming bubo from whatever cause (*Medical Fortnightly*), the application of a wad of absorbent cotton, soaked in fluid extract of phytolacca decandra, kept moist by a covering of gutta percha tissue, has been found to have marked controlling effect. The use of this remedy was suggested by its usually prompt dissipation of caked breast, when applied in a similar way.

INTERNAL ANTISEPTICS.

Salol is the best of the internal antiseptics, (*Dujardin-Beaumetz*,) because it is always well borne by the digestive tract; it is but slightly soluble, and is decomposed into carbolic and salicylic acid only in an alkaline medium, *i. e.*, in the intestine. Iodoform and naphthol, which are always toxic and irritant, are muchinf erior to it, for it is but slightly toxic. Almost equally valuable is the salicylate of bismuth, which acts on both the stomach and intestine.

℞ Salol. .....
Bismuth salicyl .....
Sod. bicarb .....aa ʒ iiss.
Div. in caps. xxx.

ENTERIC FEVER TREATED BY LIQUOR SODA CHLORINATE.

The antiseptic treatment of typhoid fever has been so highly lauded by some physicians, and has so often proved useless, that the latest suppliant for popular favor is worth mentioning,—namely, chlorinated soda. Pearson, of Cape Colony, writes to the *Lancet*, of December 5, 1891, that he has found the following method extraordinarily successful in a very large number of cases. He prescribes from fifteen to twenty minims every three or four hours of a solution made as follows, and gives no other medicine whatever, maintaining a milk diet: The solution is made by dissolving one and a half pounds of carbonate of sodium in twenty-four ounces of water, and by triturating thoroughly a pound of chloride of lime in 120 ounces of water. These liquids are now filtered and mixed together, and then again filtered. The solution should be perfectly

clear and free from traces of lime, and should be kept in a cool place. This treatment Pearson continues until the temperature has remained normal for two days.—*Therapeutic Gazette.*

TREATMENT OF SHOCK.

Chauvel recommends the following treatment of shock, according to *La Médecine Hypodermique* for January, 1892: For the purpose of reëstablishing the circulation, the patient is put in an absolutely horizontal position and massaged. He is also given alcoholic frictions and subcutaneous injections of ether. For the purpose of maintaining the bodily temperature, the air of the room is well heated, and the patient is surrounded by hot bottles, or placed in a bath of the temperature of 105° or 110°.

Internally, Chauvel administers alcoholic stimulants, such as rum or brandy, in the dose of from one to two ounces. He does not employ sinapisms or other inconvenient measures. When reaction has been obtained, the stimulants are combined with opium for the production of sleep. Chauvel mentions the intravenous injection of ammonia, as has been used by Penfold and Tibbis. In cases where shock is prolonged, strychnine, digitalis, and belladonna are to be employed, and electricity may be of great service.—*Therapeutic Gazette.*

APPLICATION FOR RHEUMATISM.

Hebbing is said to employ the following solution locally in the treatment of rheumatism:

R—Salol .....
Sulphuric ether, aa..... ℥i;
Collodion..... ℥i.

To be applied around the joints which are affected by acute rheumatism.—*L'Union Médicale.*

INTERNAL USES OF CHLOROFORM.

In an article, entitled The Medicinal Employment of Anesthetics, in *L'Union Médicale*, No. 4, 1892, after calling attention to the fact that chloroform-water is a very valuable remedy in cases of gastralgia, with dilatation of the stomach, in the dose of a small teaspoonful every half hour or hour, attention is called to its value in the treatment of nervous vomiting and of the vomiting of pregnancy. Attention is also called to the fact that Bianchi has found

that an aqueous solution of chloroform, in the strength of two per cent., is a useful liquid for the purpose of lavage. It is an analgesic and a moderator of reflex irritability.

Dujardin-Beaumetz has also found that in cases of lithiasis, suffering from gastric pain, chloroform in the following formula is very serviceable :

R—Saturated chloroform-water ..... ℥ii ;
Syrup of orange ..... ℥i ;
Simple syrup ..... ℥i.

Sig.—A dessertspoonful every fifteen minutes until the pain is relieved.

It has also been found that chloroform is equally efficacious with ether for the removal of gall-stones occurring in gouty persons.

Ulbrecht recommends that chloroform, in the proportion of one to ten, shall be used for the purpose of stopping hemorrhage after extraction of teeth.

The drug is also useful in cases of parasitic painful growths of the mouth, such as the various forms of stomatitis.

Employed in false croup, chloroform, in the proportion of one to ten drops in an ounce of water, to which is added a little glycerin, is very useful when given internally, in the dose of a teaspoonful every half hour. If there is dyspnea through the day, a teaspoonful may be given every two hours and at night every hour.

A very useful employment of chloroform is in cholera infantum in the following prescription :

R—Syrup of ginger ..... ℥i ;
Chloroform ..... gtt. iii. to iv ;
Tincture of opium ..... gtt. x to xv.

Sig.—A teaspoonful every hour.

In ulcer of the stomach, small doses of chloroform given internally will often remove the pain and stop vomiting, and chloroform-water has also been found useful as a gargle in septic sore throat.

Steep has treated eighteen cases of typhoid fever by the internal administration of chloroform, in the dose of fifteen minims in ten ounces of water, given three times a day during the attack ; at the same time quinine is employed. It is stated that this medication causes a rapid decrease in the fever, and that no disagreeable secondary effects are observed.

Roger has used three to six drops of chloroform, in syrup or mucilage, in the treatment of whooping-cough, with very good results, and in some instances the nervous excitability of delirium

tremens can be much quieted by its internal administration. The following prescription is said to have been authorized by Da Costa:

R—Chloroform ..... ℥i;
Compound tincture of cardamom ..... ℥i;
Syrup of acacia ..... ℥i;
Simple elixir ..... ℥ii.

Sig.—A teaspoonful every half hour until relief is obtained.

Miller and Griggs are said to have reached very good results in the albuminuria and anasarca of pregnancy by giving chloroform, in twelve- to twenty-drop doses in sweetened water, causing thereby a diminution in the albuminuria and the disappearance of the anasarca. This treatment is also said to have prevented the development of eclampsia.

In the treatment of tape-worm, Kaiser has used the following mixture:

R—Croton oil ..... m i;
Chloroform ..... m ii;
Castor oil ..... ℥i.

Professional opinion seems to be considerably against the employment of chloroform hypodermically, as after injection of large doses in the lower animals it has been found to create grave renal lesions with degeneration of the muscular fibres of the heart. In man, when it has been employed in the treatment of neuralgia in this manner, it has produced in a number of cases severe pain and profound alterations in the cellular tissues.

In other cases, however, very good results have followed the treatment of neuralgia by injection of from five to ten minims of chloroform into the part affected, although marked edema and swelling of the part has followed the injection.—*Therapeutic Gazette.*

INJECTIONS FOR CHRONIC CYSTITIS.

Ultzmann recommends the following prescriptions in the treatment of this troublesome condition:

Crystallized carbolic acid ..... gr. xv;
Distilled water ..... ℥iiiss.

Dissolve, and mix with equal parts of hot water at the moment that the liquid is to be injected.

Or the following:

Boric acid ..... ℥ss;
Glycerin ..... ℥i;
Distilled water ..... ℥x.

Make a solution, and mix with equal parts of warm water at the moment of employment.

Either one of these solutions when warm may be used for washing out the bladder in cases of chronic cystitis. When the vesical secretion is catarrhal and has a bad odor, the following injection is useful :

R—Nitrite of amyl..... gtt. v ;
Distilled water..... ℥iv.

Mix, and add a tablespoonful of this solution in the proper quantity of water for a vesical injection.—*L'Union Médicale*, No. 12, 1892.

Correspondence.

BERLIN LETTER.

Dr. Frank J. Thornbury discourses upon The Bacillus of Influenza. —The studies and conclusions of Dr. Pfeiffer at the Institute for Infectious Diseases.—The researches of Kitasato.

Dr. R. Pfeiffer, assistant to Professor Koch at the Institute for Infectious Diseases here, has made detailed and accurate bacteriological investigations in thirty-one cases of influenza, six of which afforded post mortem observation. The following are his results :

1. In all cases a certain form of bacillus was found in the characteristic purulent bronchial exudate. In pure cultures from all uncomplicated cases of influenza the presence of this bacillus was established, and in most instances myriads of the bacilli were present. Very frequently they were found situated within the protoplasma of the pus corpuscles. In patients attacked with influenza, who had previously been suffering from some affection of the respiratory apparatus, for instance, tuberculosis with excavation, other organisms are found in the expectoration in diffuse numbers. From the bronchi the bacilli may penetrate into the peri-bronchial connective tissue, and they may even succeed in reaching the visceral layer of the pleura, where they were found in pure cultures in two cases upon which autopsies were made.

2. These organisms are of *rod* shape, were found in cases of influenza *exclusively*. A vast number of control examinations established the fact that they are not present in ordinary cases of bronchitis, bronchial catarrh, pneumonia, and phthisis.

3. The number and presence of the bacilli are in direct relation to the course of the disease ; with the subsidence of the purulent bronchial secretion the bacilli also disappear.

4. The same bacilli in the same vast numbers occurring in the sputum of patients affected with influenza were observed and photographed by Pfeiffer two years ago when the disease first became epidemic.

5. The influenza organism is a rod-shaped *bacillus* of very diminutive size, having about the same thickness, but is only one-half as long as the mouse septicemial bacillus. Frequently three or four bacilli succeed one another in regular succession on the field, thus forming a sort of chain. With the basic aniline dyes there is considerable difficulty in staining the organism. A better preparation is found in a diluted Liehl's solution with Loffler's methyl-blue. Staining by this method it will be observed quite frequently that the end pole of the bacillus takes up the coloring matter to a much greater extent, so that an appearance is presented which may be easily confounded with diplo- or streptococci. It may, in fact, be accepted that one of the previous observers who also saw this bacillus described by Pfeiffer, by reason of this special peculiarity of staining, was deceived, and erroneously designated the germ diplo- and streptococci in his writing. The bacilli are not susceptible of staining by Gram's method. In hanging drop they have no motion.

6. They are permissible of maintenance in pure cultures. In $1\frac{1}{2}$ per cent. sugar-agar the colonies appear as exceedingly minute watery drops, often recognizable only by means of the "lupe." The further propagation of the germ in this medium is attended with difficulty, and beyond the second generation Pfeiffer has not been successful.

7. A number of attempts have been made to produce the disease in the lower animals. Apes, rabbits, guinea-pigs, rats, doves, and mice have been innoculated. These attempts have been successful only in case of apes and rabbits. The remaining species manifest a refractive tendency toward the disease.

8. In accordance with the foregoing facts, Pfeiffer maintains that the herein-described bacillus is to be accepted as the absolute cause of influenza.

9. The infection takes place in all probability through the bacteria-laden sputum, consequently as a prophylactic precaution the expectorate of all influenza patients must be thoroughly disinfected.

Kitasato has been successful in cultivating the influenza bacillus in sugar-agar to the fifteenth generation.

In presenting the subject before the Berlin Medical Faculty, at their last meeting, Kitasato preceded his remarks by stating: "It is surprising that such a long time should have elapsed before the specific infectious cause of influenza was found, considering the comparatively long time that the disease has prevailed, the vast endemic and epidemic proportions which it has assumed, and the numerous and widespread investigations which have been instituted."

The explanation according to Kitasato lies in the extreme difficulty in cultivating the bacillus. It is self-evident that without securing pure cultures a bacteriologist cannot arrive at definite conclusions with a newly-encountered pathogenic organism.

The difficulty in obtaining pure cultures from the sputum is dependent upon its multiple contamination with bacteria from the mouth and elsewhere.

By reason of the luxurious and rapid growth of these bacteria in our ordinary artificial culture mediums, the especially sought for germ is completely overgrown and covered up.

The greater the probability of this taking place is in proportion to the slowness of development in the colonies formed by the germ under consideration. This outgrowth by other organisms is well known in case of the tubercle bacillus.

In order to obviate this difficulty encountered in obtaining permanently pure cultures of tubercle bacilli from the sputum direct, Koch has not as yet made public any method by which he has, during these many years, been repeatedly successful. Notwithstanding repeated efforts, the same has been the experience of Kitasato in case of tubercle, and also as regards influenza. Kitasato has not as yet made known the method by which he has been successful in obtaining pure cultures of the influenza bacillus, but he promises very soon to do so.

In regard to the characteristics of the bacillus, his observations correspond exactly with those of Pfeiffer.

On glycerine-agar, in tubes coagulated obliquely, the individual colonies appear over the surface as exceedingly small, during the first twenty-four hours barely perceptible points resembling condensed vapor. So that macroscopically an inoculated tube is with difficulty distinguished from one sterilized.

As stated previously, the individual colonies are so exceedingly small and infinitely indistinct that they may be easily overlooked, and such, probably, has been the ill-luck of former investi-

gators. One of these small colonies transferred to a fresh agar tube leads to the development of a multiplicity of colonies recognizable on the moist surface of the agar. Especially striking in the same is the fact that the individual colonies remain isolated and separate and distinct from each other, not aggregating and forming a connected covering over the surface, as do all other forms of bacteria in cultures. This isolated growth on agar is so characteristic that the influenza may be recognized with certainty from all other bacteria.

In gelatine the germ cannot be cultivated, as below 28° C. (the coagulation point of gelatine) they do not grow.

In bullion it grows scantily. In the first twenty-four hours, one recognizes, swimming in the bullion, white crumbly particles, the bullion itself remaining perfectly clear. Later, these small particles sink to the bottom and form there a white flocculent clump, the bullion above still remaining clear,—an evidence that the bacilli are devoid of motion. Kitasato has for a long time been examining tubercular sputum, and made accurate microscopic and culture study of all microörganisms found in association with the tubercle bacillus. The sputum of pneumonia and bronchitis cases has also been examined accurately and extensively, but at no time has this "so exceedingly characteristic and easily recognizable bacillus" been seen, excepting in cases of influenza.

P. Canon in examining the blood, per stained preparation, in twenty consecutive cases of influenza, found a particular form of microörganisms present in each instance.

The examinations were conducted in the following manner: One of the fingers of the patient is punctured with a needle in the usual manner, after the usual preliminary cleansing and aseptic precautions. The drop of blood which oozes is taken up in a very thin cover-glass, over which another is laid, and the two then suddenly are pulled apart. The cover-glasses are then allowed to dry, after which they are laid in absolute alcohol for five minutes. They are next placed in a coloring solution of the following composition (Czenynke fluid): concentrated aqueous methyline blue solution, 40 grains; one-half per cent. Eosin solution (in 70 per cent. alcohol dissolved), 20 grains; aq. dist., 40 gr.

In this solution the cover-glasses are placed in the culture chamber at 37° C., and here allowed to remain for three to six hours. They are then washed out in water, dried and mounted in Canada balsam.

In the blood preparation thus made the corpuscles are stained red, while the bacilli have a contrasting blue color.

Sometimes a great number of bacilli are present; again there are only a few, four to twenty, perhaps, in the entire field, and these are scattered and seen only after continued searching. At first they appear as diplococci: soon, however, (especially easy when deeply colored,) they will be recognized as short rods.

In six cases Canon found these bacilli in the preparation of blood in numerous large groups, containing from five to fifty bacilli each, and presenting a very characteristic appearance.

The blood was obtained in these six cases during the temperature elevation, or very soon after its decline. In three of the cases there was no further rise of temperature, and in six days there were no bacilli to be found.

In a patient of Professor Guttmann's, where the diagnosis was doubtful, Canon was able to state positively, by examination of the blood, that the case was one of influenza.

Also in other instances were the bacteria found in the blood, and even in great numbers where no local symptomatic evidence was present, especially no cough and expectoration.

Canon inoculated (per striate) tubes of agar, glycerine-agar, sugar-agar, and bullion, at the same time and from the same specimens of blood that he had examined microscopically.

In six cases the inoculated bullion was injected into mice, three at once, the remainder the following day, after which they were placed in a warm chamber. These injections, however, and examinations of the animals, gave negative results. [NOTE.—As previously stated, only monkeys and rabbits are susceptible to the disease according to Pfeiffer.]

In accordance with his investigations, Canon is of the opinion that this organism occurs in the blood in all cases of influenza (at least in all cases attended with fever), that it is not found in the blood of other cases, and that it stands, therefore, in direct causative relation to the disease.

Koch himself examined the blood preparations made by Canon, and pronounced the bacillus found in them identical with those found by his assistant Pfeiffer.

The blood investigations by Canon were begun about the middle of December, and he has still a great number of preparations to color and examine, and will thus continue his observations.

Last November, Lawrence demonstrated in Professor Nothnag-

gel's Clinic at Vienna, a microörganism found in the sputum of patients suffering with influenza.

The organism was a coccus, and resembled the Fraenkel-Weipselbaum diplococcus of pneumonia, excepting that it was much smaller. It had the Liehl stain, and appeared under the microscope as an ordinary streptococcus.

Sometimes a dozen or more of these organisms would be seen in the cells of the bronchial exudate, forming a quite perfect chain. They seemed to multiply with great rapidity, and were found in the blood; especially in cases of high temperature range were they numerous.

Lawrence regarded the germs as of an especially virulent disposition and pathogenic. He stated that we might with a reasonable degree of certainty accept them as the cause of the disease.

The reason of their appearing as diplococci is sufficiently explained by the peculiarity of staining, to which Pfeiffer directs attention. F. J. T.

63 Kloster Strasse, Berlin, January 28, 1892.

NEW BUILDINGS FOR THE JEFFERSON MEDICAL COLLEGE OF PHILADELPHIA.

The Jefferson Medical College authorities have just completed the purchase of two large lots, on Broad street, upon which they will proceed to erect at once a handsome hospital, lecture hall, and laboratory building. The hospital will be built not only as a suitable building in which to care for the sick and injured, but also will be provided with a large amphitheatre for clinical lectures. By the erection of three commodious buildings, the laboratories, where delicate work with the microscope or apparatus is carried on, will be separated from the college hall, where didactic lectures are given, and so will be free from any jarring produced by the movement of large classes. With the hospital on one side, affording clinical facilities, and the laboratory on the other side of the college hall, for scientific research and training, the college will be most favorably situated for giving thorough instruction in medicine. The move has been made necessary by the large number of students who are now being instructed in this institution, and because the Faculty desire to keep the school and hospital in the foremost rank of medical education in this country. The building will be ready for occupancy in the session of 1893–'94.

BUFFALO MEDICAL AND SURGICAL JOURNAL

A MONTHLY REVIEW OF MEDICINE AND SURGERY.

EDITORS:

THOMAS LOTHROP, M. D. - - WM. WARREN POTTER, M. D.

All communications, whether of a literary or business character, should be addressed to the managing editor: 281 FRANKLIN STREET, BUFFALO, N. Y.

VOL. XXXI. APRIL, 1892. No. 9.

THE BUFFALO ACADEMY OF MEDICINE.

THERE is a movement on foot to concentrate the medical intellect of the city in an organization with the above title. Last Autumn, the Buffalo Medical and Surgical Association, the Buffalo Obstetrical Society, the Buffalo Pathological Society, and the Buffalo Clinical Society, each appointed a committee from its members to meet the committee of the other societies to consider the advisability of the formation of such an organization. These committees met, and after full discussion, concluded that such action was advisable, and that the time was ripe for the formation of an academy. After making such report to their respective societies, the committees were continued in existence and directed to complete plans for such organization.

This work the committees have done. Reports of the plan of organization have been made to the Pathological Society and to the Obstetrical Society, and will be made, at their next meetings, to the Medical and Surgical Association and to the Clinical Society.

The Pathological and Obstetrical Societies, after full discussion of the plans as suggested by the committee, have voted to enter into the organization, if certain minor alterations be made in the plan.

In the proposed constitution, which is modeled after that of the New York Academy of Medicine, the object of the academy is stated to be "the promotion of the science and art of medicine, including the maintenance of a medical library and a museum."

It is expected that the academy will rent for a while and eventuually own a building which will be a center where the medical men of the city may meet, possess a library which all can consult, and a museum where any can study whatever particular subject he wishes to investigate.

It is to be hoped that the medical men of the city will enter into this undertaking in a liberal and generous spirit, and establish an academy worthy of a city which maintains two medical schools of such high standing, and numbers among its citizens medical men of national—nay, even world-wide—reputation as authorities in their profession.

The JOURNAL pledges itself to a hearty coöperation with the projectors of this commendable enterprise in perfecting it and promoting its greatest usefulness.

THE NEW YORK PHYSICIANS' MUTUAL AID ASSOCIATION.

WE HAVE heretofore directed the attention of our readers to the beneficent work of this medical association, which admits to its membership any regular physician who is a resident of New York State, under fifty years of age, and in good health. The annual report for 1891 is before us. The most striking feature therein contained is the fact that over $83,000 have been paid to the families of deceased members since its organization, twenty-four years ago.

The steady growth of the Benevolent (permanent) Fund, the interest of which is available for aiding poor and distressed members, by loans or donations, is another very gratifying evidence of the wise administration of the Board of Trustees, which, it should be stated, has always served the society without any compensation, except the satisfaction of aiding the unfortunate in our ranks.

The growth of the membership has been rapid of late years, and there are now over one thousand names upon the roll, hence the Trustees will very soon be able to pay $1,000 upon the death of a member. We believe it is a duty we owe each other as members of the profession to unite with the Association,—those who are prosperous, for the privilege of assisting the less favored, and those who may be less fortunate, to provide for those who may be dependent upon them for support.

The expense of membership is small, not over $15 annually.

The number of members in Buffalo alone should be at once increased to at least 100. Application may be made through Dr. W. G. Gregory, No. 530 Main street, Dr. S. A. Dunham, No. 72 West Chippewa street, or to the Secretary of the Association, Dr. J. E. Nichols, 456 Lexington avenue, New York City.

THE PAN-AMERICAN MEDICAL CONGRESS.

We publish, on another page, a circular of information from the Secretary-General, Dr. Charles A. L. Reed, though it is signed in his capacity as Chairman of the Committee of Organization. This is simply because it contains the preliminary features pertaining to the organization of the Congress that were inaugurated under the Committee before he was elected Secretary-General. This is probably the last circular that will be signed in this way, as in the future all his duties will be performed under his authority as Secretary-General. We trust that all interested in this Congress will read carefully the general and special regulations, that they may familiarize themselves with their details, and especially is it considered important that those who intend to become members shall forward their registration fee to the Treasurer, Dr. A. M. Owen, Evansville, Ind., without delay.

The incorporation of the Congress under the laws of Ohio was a wise act on the part of the officers, because it removes it from the shadow or control of any organization, clique, or association. It is now a Congress pure and simple, acting for itself, with its own autonomy, under the authority of law, and can both receive and bestow contributions of money without danger of being charged with illegality by such acts. The Congress has made such rapid progress towards organization in other countries, that it will be very easy to organize all the work pertaining to the United States as soon as the committee shall have made its next report to the American Medical Association, at which time its relations to that body will naturally cease. We bespeak for it the encouragement that it deserves from every American physician, as well as every good citizen.

EDITOR'S DRAWER.

The electro-gynecologists, having driven their batteries at a galloping pace through the female pelvis, are now turning their attention to a corresponding portion of the male anatomy. The prostate gland is the first object that arrests their attention, but we may expect soon to hear of the conquest of other organs in its vicinity.

The Medical Society of the State of New York, at its last meeting, appointed a committee of seven to coöperate in promoting the interests of the Pan-American Medical Congress in this State. The

committee consists of Drs. A. Walter Suiter, of Herkimer; A. Vander Veer, of Albany; James D. Spencer, of Watertown; Seneca D. Powell, of New York; William Warren Potter, of Buffalo; D. B. St. John Roosa, of New York, and John O. Roe, of Rochester.

The *New York Medical Record* publishes a list of National and State medical societies, giving the names and addresses of the President and Secretary of each, together with the time and place of the next meeting. This furnishes a convenient reference for all interested in these societies, and entitles the *Record* to the thanks of the profession for its considerate thoughtfulness in this regard. We note an error in the announcement of the Medical Society of the State of New York in that the President this year is Dr. Lewis S. Pilcher, of Brooklyn. Dr. Suiter was the presiding officer during the last session.

The committee appointed at the last meeting of the American Medical Association to consider the best means for promoting the prosperity of the sections of the association, will hold an adjourned meeting in the Hotel Cadillac, Detroit, Mich., June 6th, at 3 P. M. Members of the committee are requested to notify the chairman of their intention to be present at this meeting. The committee would esteem it a favor if each member of the association would communicate in writing his or her views concerning the best measures for promoting the development of the sections. Such communications may be sent to the Chairman of the Committee, John S. Marshall, M. D., 9 Jackson street, Chicago.

The Committee on Public Health of the State Legislature, at a hearing held in Albany, February 24, 1892, listened to arguments pro and con relating to the baby Students' Bill No. 513. A very tame and weak opening was made on behalf of the students, which was followed by Dr. Edward Clark, of Buffalo, in opposition to the bill, who packed more solid logical argument into a fifteen minutes' speech than is common at such a hearing. He was followed by some other speakers, and the argument was finally closed by Dr. D. B. St. John Roosa, of New York, chairman of the legislative committee of the state medical society, who clinched the case with a few telling sentences that he is so capable of delivering. If there

is anything in argument, or logic, or reason, it would seem as though the public health committee could not fail to be influenced by the earnest remarks of these gentlemen, who voiced the entire medical profession of the State of New York. The bill should slumber in the committee until the crack of doom.

Nominations were made by the Medical Society of the State of New York to fill vacancies on the State Board of Medical Examiners as follows: Dr. J. P. Creveling, of Auburn; Dr. Eugene Beach, of Gloversville; Dr. B. F. Sherman, of Ogdensburgh; Dr. A. Walter Suiter, of Herkimer. The term of service of Drs. Creveling and Beach will expire September 1, 1892, and from the four names submitted, as above stated, the Board of Regents will make appointments to fill these vacancies.

Dr. R. French Stone, of Indianapolis, Ind., as editor and business manager for the publishers, Messrs. Carlon & Hollanbeck, announces the publication in the near future of a biography of eminent American physicians and surgeons. The work will be sold by subscription only, and it is proposed to limit the edition to between five and ten thousand copies, according to the number of subscriptions received. It is expected to complete the work before the close of the present year; hence it is desirable for all who wish the book to subscribe at an early date. The value of such a work cannot be questioned, as it enables one to readily refer to the status of a man whose personal acquaintance he may not have enjoyed. This and many other reasons conspire to make the book one which merits the support of the profession. The prices range from $8.00 to $10.00, according to the style of binding, and remittances may be made to Dr. Stone, 16 West Ohio street, Indianapolis, Ind.

The average politician or capitalist has very little sympathy and less knowledge about the conduct of affairs in the public health service. Each of these classes generally thinks it a shrewd trick to keep the expenses of that department down to a minimum, which, judged by the standard of other departments, may be easily characterized as niggardly.

When Dr. Wende, the Health Commissioner, entered upon the duties of his office, he evidently did it with the intention of making the department what it should be in a great city like Buffalo. His

recent visit to Indianapolis and Chicago, accompanied by Dr. Heath, the Food and Drug Inspector, will result in great good, we feel assured.

It is a strange revelation to find the city of Indianapolis, with a population less than one-half of that of Buffalo, appropriating several thousand dollars more annually to maintain something like a proper sanitary status. Chicago, only four times the size of Buffalo, maintains a health department at an expense of $600,000 annually, while the present officials of this city think $25,000 enough to allot this important department of the public service. Comment is unnecessary. The contrast is too striking to make it otherwise than painful to any physician who has the best interest of the city at heart.

Personal.

Dr. E. E. Montgomery, having resigned the obstetrical chair in the Medico-Chirurgical College of Philadelphia, will hereafter devote himself entirely to teaching in the gynecological department of that college.

Dr. Joseph Price, of Philadelphia, has been for a few years past the physician in charge of the Preston Retreat, which is one of the largest maternities in this country. During his service, now something like four years, there have been 1,050 confinements in that institution, including one Porro-Cesarian section, without a death. This is one of the most satisfactory records that has been made in any maternity, and speaks volumes for the modern methods of hygiene, sanitation, and obstetrics enforced and practised in that institution.

Dr. Richard Curran, of Rochester, was elected Mayor of the Flower City, on Tuesday, March 7, 1892, by a majority which may reach 3,500 over the present incumbent, Mayor Carroll. Dr. Curran served during the entire civil war, having entered the service as an enlisted man, and when mustered out he was surgeon of the Ninth N. Y. Cavalry, a regiment raised principally in Chautauqua county. The election of Dr. Curran is another instance of the physician in politics, but no city can make a mistake when it elevates a physician of such sterling qualities as Dr. Curran to its chief magistracy.

Dr. John C. Fisher, late of the U. S. Marine Hospital Service, has located in Warsaw, N. Y., where he has established a sanitarium which is of the very first order. It is a most complete establishment of its kind, where salt baths can be had without the dangers of the surf. Dr. Fisher's sanitarium is located on a hillside, overlooking the beautiful Warsaw valley, and is one of the most picturesque spots in Western New York. Physicians who have patients requiring the rest and advantages of a sanitarium will find this one conducted on the strictest scientific and ethical principles. No physician need hesitate to send a patient there on account of fear that he will be supplanted or undermined.

Dr. James F. W. Ross, of Toronto, Ont., the leading abdominal surgeon in Canada, has recently paid a visit to Buffalo. Dr. Ross speaks in highest terms of many of the improved features of our growing city since his last visit, and promises that the time between this and his next will not be as long as before—in other words, that he will come and see us again soon. We shall always be pleased to welcome him.

Dr. John A. Ouchterlony, of Louisville, Ky., has been decorated by the King of Sweden with the Royal Order of Knight of the Polar Star. This knighthood is conferred only on those who have become famous as statesmen, scientists, great writers, etc., and was founded by King Frederick the I. of Sweden in 1738. Dr. Ouchterlony is of an illustrious Swedish family, distinguished for scientific research, and is recognized as one of the foremost American physicians. He is one of the honorary chairmen of the section on Practice of Medicine of the Pan-American Medical Congress, Professor of Practice of Medicine in the University of Louisville, and is regarded by the profession in that city as their most skilled practitioner and consultant on internal medicine. He is an accomplished linguist, a profound pathologist, and an expert diagnostician. Though this is a free American republic, we recognize the fitness of the royal honors that have been bestowed upon Sir John Ouchterlony, A. M., M. D.

Mrs. Gladstone's first article in the series of Hints from a Mother's Life, which she has written for *The Ladies' Home Journal*, will be printed in the April issue of that periodical.

Obituary.

Dr. John Davidson Hill died at his residence in Buffalo on the 27th day of February, 1892, in the seventieth year of his age. The deceased had been for upwards of forty years a prominent practitioner of medicine in this city, and had attained a degree of eminence which placed him in the first rank. He had been President of the Medical Society of the County of Erie, was member of the board of managers of the Buffalo State Hospital, and had occupied many other places of honor in both business and professional capacities. He was one of the last representatives of the many prominent physicians of his period, and his loss will be long deeply felt by a large circle of friends and patrons. Under the head of "Society Proceedings" we publish in this issue the action of the Medical Society of the County of Erie relating to this melancholy event.

Society Meetings.

The American Medical Association will hold its forty-third annual session, in Detroit, on Tuesday, Wednesday, Thursday, and Friday, June 7, 8, 9, and 10, 1892. Dr. Henry O. Marcy, of Boston, is president, and Dr. Henry O. Walker, of Detroit, is chairman of the Committee of Arrangements. The general addresses will be delivered by the following named gentlemen: On General Medicine, Dr. J. S. Cain, of Tennessee; on General Surgery, Dr. John B. Hamilton, of Illinois; on State Medicine, by Dr. C. A. Lindsley, of Connecticut. It is anticipated that this will be one of the most successful meetings of the Association, and the local committee in Detroit is making rapid progress in perfecting arrangements to care for a large gathering.

Dr. E. E. Montgomery, chairman of the section of Obstetrics and Diseases of Women,—address, 1818 Arch street, Philadelphia,—would be glad to receive the titles of proposed papers from those who desire to take part in the proceedings of this section at the next meeting of the Association. It is important that titles should be presented as early as possible, in order to make proper arrangements for their careful consideration and discussion.

The first Pan-American Medical Congress will meet in Washington, D. C., on Tuesday, Wednesday, Thursday, and Friday,

September 5, 6, 7, and 8, 1893. The Congress will be presided over by Dr. William Pepper, President, of Philadelphia. The Secretary-General, Dr. Charles A. L. Reed, of Cincinnati, has displayed rare executive capacity in so completely putting the machinery of the Congress in working order as to already assure its success. Dr. A. M. Owen, of Evansville, Ind., is Treasurer, and it is desirable that all the officers of the Congress, and as many as possible of those who desire to take part therein, pay in the membership fee of $10.00 at an early date.

An International Periodical Congress of Gynecology and Obstetrics has been called, and its first session will be held in Brussels, Belgium, September 14 to 19, 1892. Dr. Jacobs, of 12 Rue des Petits-Carmes, Brussels, is the Secretary-General, and Dr. F. Henrotin, 353 La Salle avenue, Chicago, is the American Secretary, and all communications from this country should be addressed to the latter.

Mr. Lawson Tait will preside at the Congress, and the leading questions offered for discussion are as follows:

1. Pelvic Suppuration, referee, Dr. Paul Segond, Paris.
2. Extrauterine Pregnancy, referee, Dr. A. Martin, Berlin.
3. Placenta Previa, referee, Dr. Berry Hart, Edinburgh.

The indications are that this will be a large meeting of the leading obstetricians and gynecologists in the world.

Book Reviews.

A Practical Treatise on the Diseases of Women. By T. Gaillard Thomas, M. D., LL. D., Emeritus Professor of Diseases of Women in the College of Physicians and Surgeons, New York, and Paul F. Mundé, M. D., Professor of Gynecology in the New York Polyclinic. New (sixth) edition, thoroughly revised and rewritten by Dr. Mundé. In one large and handsome octavo volume of 824 pages, with 347 illustrations. Cloth, $5.00; leather, $6.00. Philadelphia: Lea Brothers & Co. 1891.

It is twenty-four years since Thomas first appeared as an author upon the subject of Diseases of Women. For twelve years, or one-half of that period, he held undisputed sway in America, and was quoted as the supremest authority upon all subjects pertaining to operative as well as minor gynecology. Not only this, but the marked favor with which the early editions of his work was

received in Europe is evidenced by the fact that it was translated into German, French, Italian, and Spanish, and, hence, obtained a widespread circulation throughout continental Europe. During this period five editions of the work were published,—an average of one edition for every two years and a half of its life.

From the fifth edition, which appeared in 1880, down to the one now under consideration, no attempt has been made to revise or keep the work abreast of the progress of gynecological science. This may seem strange, for it is really during this period of quiescence on the part of Thomas as an author that gynecology has made its greatest strides, overleaping all the barriers which seemed to lie athwart its path, and trampling down all the traditions which the early teachers had built upon. It must be confessed that much of the teaching of the early editions has become obsolete, or nearly so, hence the volume has very much depreciated as a guide to students or practitioners. To let such a valuable treatise die during the life of the author, seemed to be almost inexplicable, and we can well understand how the pride of Thomas in his earlier editions, the reception they received both in America and Europe, and his popularity as a teacher, would conspire to prevent, if possible, such a misfortune to his book. The difficulty seems to have been to find a person who would revise the author's work to his satisfaction, and at the same time bring it forward to conform, in main respects, to the requirements of the present day.

The selection of Dr. Paul F. Mundé was in every point of view a happy solution of the difficulty. Dr. Mundé ranks as one of the progressive gynecologists of the period, and is at the same time sufficiently conservative on many subjects to bring him into sympathy with Thomas, and the men of his age and trend of thought. We have examined the sixth edition of Thomas, so thoroughly revised by Mundé, with some degree of care, and we are of the opinion that it would be difficult to find more faithful work on the part of a reviser than the pages of this book exhibit. Wherever there has been a difference of opinion between the author and the editor, the latter has not failed to make himself distinctly understood upon such points of difference. These notes of the editor are included in brackets, and serve to add to the interest of the work.

To show how complete a change of front often takes place in the mind of an author, with reference to some questions as years progress, let us cite an instance. In Thomas's first edition, and for

the succeeding four issues, he was an advocate of sponge tents, as well as those made of other material, for the dilatation of the os uteri under certain conditions. On page 98 we find the following in brackets:

NOTE.—Since the last edition, Dr. Thomas's position in regard to tents has changed to such a degree that in a communication on the subject received from him after this chapter had gone to press, he says: "Tents of all kinds should be discarded in gynecology, absolutely and completely. Dilatation of the os uteri can be more certainly and completely accomplished by rapid dilatation by the divulsor under anesthesia and careful antisepsis, and should always be practised by preference." I am not personally prepared to go as far as this, and should be sorry to be compelled to part with the tupelo tent in certain cases where a gradual, slow, and thorough dilatation is desired. Sponge and laminaria I have not employed for years. Feeling that a sweeping condemnation of tents in gynecology would scarcely meet with the approval of the profession, and believing, as I do, in their limited utility, I have thought it my duty to endeavor to instruct the practitioner how to use them with as little risk as possible, and have, therefore, retained this section.

In this position we lean towards the opinion of the author as against that of the editor. We are perfectly willing to admit that a tupelo tent in the hands of Dr. Mundé, or in the hands of men with experience equal to his, may be a safe instrument, but we are of the further opinion that it is safer to adhere to the position taken by the author, in a text-book at least, than to that of the editor. We believe that gynecology can afford to part with all kinds of tents, and if it should it will not thereby be the loser.

Dr. Mundé has introduced a short chapter on Electricity as a Therapeutical Agent in Gynecology. Since there are a number of well-meaning physicians who think they have discovered in electricity the agent which is the *summum bonum* of therapeusis, it is well to have this subject dealt with in a text-book, in an intelligent fashion, by a man who has a considerable experience with it, and one who is willing to record its failures as well as its presumed successes. Such a man is Dr. Mundé, and the profession is familiar with his opinions in reference to this agent, since they have been published from time to time in the *American Journal of Obstetrics*. But we are of the opinion that Dr. Mundé's electrical friends will feel that he has done the subject up in too summary manner in the seven pages that he devotes to it in this book. For ourselves, we are quite content that he has taken up no more valuable space with

an agent that is little understood, and, we fear, has in it less possibilities for good than for harm in the hands of the average practitioner. Only the exceptionally few experts can be trusted not to do damage with it, and even they are not sure as to how much cure there is in it.

A new chapter has also been introduced on Hermaphrodism, one on Diseases of the Urethra and Bladder, and one on Diseases of the Female Breast. The chapters on Parauterine Cellulitis, and on Pelvic Peritonitis, have been revised with the intention of bringing them down to the latest date, but we are sorry to find omitted some of the principles that have been recently taught by Tait, Price, McMurtry, and others, on this interesting and important subject. The chapter on Pelvic Hematocele also might bear some further reconstruction in view of its intimate relationship to Extrauterine Pregnancy. The strong points in Thomas's book are where he deals with disorders of menstruation with the use of pessaries and with plastic operations on the genital tract.

Taken all in all, it is a most valuable guide to the student and practitioner, and is a work which the gynecologist must not exclude from his book shelves. We cannot commend too highly the faithful work that Dr. Mundé has performed in revising this book, and his labors entitle him to the gratitude of his readers everywhere. A large number of new illustrations have been introduced, and the press-work is of the best.

Wood's Medical and Surgical Monographs, consisting of Original Treatises and Reproductions, in English, of Books and Monographs selected from the latest literature of foreign countries, with all illustrations, etc. Published monthly. Vol. XII. No. 1. October, 1891. No. 2. November, 1891, and No. 3, December, 1891. Price, $10.00 a year; single copies, $1.00. New York: William Wood & Co. 1891.

The articles in the October number are: Treatment of Diseases of Women, by Thure Brandt; The Modern Treatment of the Morphine Habit, by Dr. A. Fromine; A Contribution to the Study of So-called Scarlatina Puerperalis, by Prof. Dr. Renvers; The Influences of Alcohol upon the Organism of the Child.—A Pharmacological-Clinical Study, by Prof. R. Demme; The Diseases of Development, by Dr. J. Comby. The first paper is of sufficient importance to demand a critical examination.

About a hundred years ago, Mr. Ling, the father of modern gymnastics, and the greatest gymnast of his time, then professor

at the Military Academy of Carlberg, Stockholm, proposed and taught what he called sick-gymnastics, his idea being that nearly all diseases of the race might be ameliorated or cured by proper movements and manipulations of the different parts of the body, if intelligently applied. The idea thus communicated to his pupils has never been lost sight of in Sweden, though its value remained obscured for many years. Within the last three or four decades the subject has received the attention of the medical world, and many intelligent physicians have recognized its therapeutic value, chiefly under the form known as massage, and the theory of the treatment seems to rest on a scientific basis. While this appears to be admitted by good professional authority, we may question its adaptability to general gynecological practice, so much depending on a certain mechanical aptness, almost amounting to sleight-of-hand, which seems to be possessed by the author, and which may be difficult to transmit to others, however well fitted they may be otherwise for the work. Perhaps we can give no more succinct idea of the author's method than by quoting a passage from one of the opening paragraphs.

He says :

In the Summer of 1847, a patient called upon me for relief from a suddenly developed prolapse of the rectum. As medical aid could not be obtained at once, and I was ignorant of the medical treatment of such cases, I conceived an idea, which was carried out in the following manner : I placed the patient in a bent semi-recumbent position, pushed the right hand in the left hypogastrium deep into the pelvis, and made traction inward and upward, combined with gentle shaking. In this way I proposed to obtain hold below the flexure of the large intestine and thus draw the gut mechanically upwards. This succeeded so well that the gut was reduced and has not again prolapsed.

Though this will give an idea of Mr. Brandt's method, nothing but a careful perusal of the monograph will give any idea of its successful application to nearly every disease to which the viscera of the female pelvis are subject.

Copious illustrations of the various gymnastic movements are given in rather rude but intelligent wood-cuts, and schools for teaching its intelligent use have been established in various parts of the world. In the treatise before us, however, we have the experience of a gentleman who has a wide European reputation as a successful manipulator in the direct application of his art to many diseases heretofore supposed to be beyond any aid but the surgeon's

knife. Mr. Brandt is not a physician, though it is evident that he is well acquainted with the anatomy and physiology of the human frame, especially of the pelvic organs, which have formed the principal parts to which he has devoted his attention.

One word by way of caution: While we do not question the propriety or usefulness of Mr. Brandt's mechanical treatment of pelvic diseases when their serious nature may require more or less heroic practice, we are satisfied that abuse may attend an indiscriminate use of massage, as tending to unnatural excitement of the nervous system, more especially in organs of great sensibility. Great as is the latitude of the physician in professional treatment of physical ailments, he ought to remember that his honor is pledged that no needless act of his wounds the natural modesty of his patient.

In the November number are found the following: The Practice of Hypnotic Suggestion, being an Elementary Hand-book for the Use of the Medical Profession, by George C. Kingsbury, M. A., M. D.; A Practical Manual of the Bacteriological Analysis of Water, by Dr. Miquel.

The December number contains: Modern Materia Medica, with Therapeutic Notes, by Dr. Otto Roth; Index to Vol. XII. This number closes the series, and their publication ceases. We are sorry to lose these valuable periodicals, for they have furnished a vast amount of excellent literature at a most reasonable cost. We advise those who have not already obtained the entire series to send their orders to the publishers at once, before they are out of print.

A Practical Treatise on Diseases of the Ear, including a Sketch of Aural Anatomy and Physiology. By D. B. St. John Roosa, M. D., LL. D., Professor of the Diseases of the Eye and Ear in the New York Post Graduate Medical School, and President of the Faculty; Surgeon to the Manhattan Eye and Ear Hospital; Consulting Surgeon to the Brooklyn Eye and Ear Hospital; formerly Professor of Ophthalmology in the University of the City of New York, and of Diseases of the Eye and Ear in the University of Vermont; formerly President of the Medical Society of the State of New York, etc., etc. Seventh revised edition. New York: William Wood & Co. 1891.

Otology has finally become recognized the world over as a distinct specialty. It is no longer considered as a matter of course that an ophthalmologist must also treat the ear, though frequently men are found who cultivate both specialties. The eye and ear

have no special anatomical relationship, and whoever would practise either or both of these specialties must necessarily study them as distinct entities, only controlled and linked together by that same general law which makes any one organ of the body an essential factor to the complete and perfect whole. Dr. Roosa has been for twenty years as recognized authority in diseases of the ear, which is the line upon which he has won his greatest renown, though he is well known also in the department of ophthalmology. When the first edition of this book appeared, now almost nineteen years ago, the distinguished author had already an experience of nearly four thousand cases upon which to base his observations and from which to deduce his conclusions. He has revised and reissued the book from time to time, keeping it abreast of the progress of otology in every respect, and now, after nearly twenty years from its first appearance, it is presented to us with the ripened judgment of a master.

The historical sketch of the progress of otology, which occupies the first forty pages of the book, is one of the most interesting sketches of the march of science in a special department of medicine that we have ever read, and it will repay any student or practitioner to study it carefully as a medical classic. Dr. Roosa's style is so clear and forcible that he cannot be misunderstood when he lays down a proposition, a law, or when he teaches a fact. In view of the recent prevalence of influenza, and the marked secondary conditions that it leaves along its trail, involving the upper air passages, and, in many instances, the internal ear with them, it would be well for the general practitioner to study carefully such a treatise as Roosa has given us, that he may have some understanding of the nature of the structures that have been invaded, and be able to place an intelligent interpretation upon the symptoms that lurk in the wake of "la grippe." More even than this, let every student obtain Roosa's book and make it his guide in his after professional life, so far as he may have to do with the ear, either directly or indirectly, as a specialist or general practitioner. Roosa's book must be to American medicine an authority upon the ear, as Gruber's is to the German school of medical science.

The book is well illustrated, handsomely printed, and copiously indexed, and commends itself to professional favor even now stronger than ever, notwithstanding the fact that so many rivals have sprung up since it first appeared. The author is still a young man, with all the vim and enthusiasm of youth, coupled with the

strength and maturity of middle age. We expect that Roosa will be quoted as authority in this specialty of otology for at least twenty years to come. He is a safe teacher and a brilliant practitioner in this somewhat subtle, though interesting and important, department of medical science.

A System of Practical Therapeutics. Edited by Hobart Amory Hare, M. D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College, Philadelphia. Assisted by Walter Chrystie, M. D., late Physician to St. Clement's Hospital, and Instructor in Physical Diagnosis in the University of Pennsylvania. Volume I., General Therapeutic Considerations, Prescription-Writing, Remedial Measures other than Drugs, Preventive Medicine, Diathetic Diseases, and Diseases of Nutrition. With illustrations. Volume II., Fevers, Diseases of the Respiratory System, Circulatory System, and Hematopoietic System, and Diseases of the Digestive System. With illustrations. Philadelphia: Lea Brothers & Co. 1892.

This work, as its title indicates, is of an encyclopedic nature, and there are seventeen contributors to Volume I. besides the editors. Volume I. deals with General Therapeutic Considerations, by Horatio C. Wood, M. D.; Prescription-writing and the Combination of Drugs, by Joseph P. Remington, Ph. D. These two titles may be considered as introductory. Then comes the section on Remedial Measures other than Drugs, and under this class we find Electro-Therapeutics, by A. D. Rockwell, M. D.; the Rest-Cure for Neurasthenia and Hysteria, by John K. Mitchell, M. D.; Swedish Movements and Massage, by Benj. Lee, M. D.; General Exercise, by Edward Mussey Hartwell, M. D.; Climate, by Edwin Solly, M. R. C. S.; and Hydrotherapy and Mineral Springs, by Simon Baruch, M. D. Then follows the section on Preventive Medicine, including General Sanitation, by Henry B. Baker, M. D.; Disinfection, by Geo. M. Sternberg, M. D.; Antisepsis and Asepsis, by J. William White, M. D.; Nutrition and Foods, including the Treatment of Obesity and Leanness, by I. Burney Yeo, M. D.; and, finally, Diathetic Diseases and Diseases of Nutrition are discussed under the following heads, viz.: Tuberculosis, by Solomon Solis-Cohen, M. D.; Scrofula and Rachitis, by Walter Chrystie, M. D.; Acute and Chronic Articular Rheumatism, Rheumatoid Arthritis, and Gout, by James Stewart, M. D.; Scurvy, by John B. Hamilton, M. D.; Diabetes Mellitus, by Frederick A. Packard, M. D. This volume consists of 1052 handsomely printed pages, and closes with an elaborate index.

Volume II. has twenty-six contributors, exclusive of the editors, and opens with an article on Syphilis, by Robert W. Taylor, M. D., which is a conclusion of the section of Diathetic Diseases and Diseases of Nutrition, commenced in Volume I. The next section is upon Fevers, and we find the first title Scarlet Fever, Measles, Rotheln, and Varicella, by J. Lewis Smith, M. D.; then follow in their order Small-Pox, by William M. Welch, M. D.; Typhoid Fever, by Frederick P. Henry, M. D.; Typhus Fever, by Manuel Dominguez, M. D.; Malarial Diseases and Dengue, by George Dock, M. D.; Yellow Fever, by Jerome Cochran, M. D.; Cerebro-Spinal Fever, by J. C. Wilson, M. D. The next section is on Diseases of the Respiratory System, and embraces Diseases of the Nasal Chambers, by Ralph W. Seiss, M. D.; Diseases of the Pharynx and Larynx, by Charles E. Sajous, M. D.; Diphtheria and True Croup, by J. Chalmers Cameron, M. D.; Asthma, Acute and Chronic Bronchitis, and Whooping-Cough, by James T. Whittaker, M. D.; Pulmonary Emphysema, Atelectasis, Abscess, and Gangrene, by M. Howard Russell, M. D.; Croupous and Catarrhal Pneumonia, by Edwin E. Graham, M. D.; Diseases of the Pleura, by Rudolph Matas, M. D.

The next section is on Diseases of the Circulatory System and Hematopoietic System, and includes Acute and Chronic Diseases of the Heart, by W. H. Thomson, M. D.; Nervous Diseases of the Heart, by T. Lauder Brunton, M. D.; Diseases of the Blood-vessels and Diseases of the Blood, by Frederick C. Shattuck, M. D.; Diseases of the Liver, Gall-bladder, Hepatic Ducts and Spleen, by J. H. Musser, M. D.; Diseases of the Thymus and Thyroid Glands, and Exophthalmic Goitre, by Richard C. Norris, M. D.

The final section of this volume is on Diseases of the Digestive System, and embraces Diseases of the Mouth and Salivary Glands, including Mumps, by A. D. Blackader, M. D.; Acute and Chronic Gastric Catarrh, Gastric Atrophy, Gastric Ulcer, Gastric Cancer, and Gastric Dilatation, by D. D. Stewart, M. D.; Cholera Morbus, Cholera, Cholera Infantum, and Dysentery, by Frederick E. Packard, M. D.; Obstruction of the Intestines, by Edward Martin, M. D.; Peritonitis, Appendicitis, and Perityphlitic Abscess, by Roswell Park, M. D.; and Diseases of the Rectum and Anus, by Charles B. Kelsey, M. D.

This volume contains 1158 pages, including a voluminous index, and is in every way the counterpart of Volume I., in its paper, press-work, and general make-up, which are all of the very best that

experienced medical book-makers can produce. It is expected that Volume III., to be issued soon, will close this valuable contribution to medical and surgical therapeutics, which has been a stupendous undertaking for the young and accomplished editor.

A Text-book of Physiology. By M. Foster, M. D., LL. D., F. R. S., Professor of Physiology in the University of Cambridge, England. Fourth American, from the Fifth English edition, thoroughly revised. Octavo, 1072 pages, 282 engravings. Cloth, $4.50; leather, $5.50. Philadelphia: Lea Brothers & Co. 1891.

The author of this book is not a stranger to the professional world. His fame as a teacher is known on both sides of the Atlantic, and his text-book has been accepted as a standard authority on physiology in Europe and America. This fourth American edition has been enriched by some changes and additions, but the general character of the treatise is much the same as was presented in previous editions. The changes made are chiefly explanatory, and do not affect especially the underlying principles that prevail in the physiological laboratory. The author does not claim that this treatise is especially rich in histological research, though he has introduced many statements in histology that deserve to be considered and stated as a part of the physiological teaching, having kinship to the general subject of physiology. The English edition of the book appeared in parts, but these have been grouped in one volume by the American editor, whose name, however, does not appear. It is quite unnecessary to undertake a critical review of a standard treatise on physiology that has already passed through several editions, and has become accepted authority. We have examined the book before us with sufficient care to satisfy ourselves that Foster is an author who has the enthusiasm of the student, together with the balanced judgment and skill of the teacher. This last edition of his treatise will most easily find for itself a place on the book shelves of every teacher of physiology in our American schools, and must be given place in the list of text-books as a guide to the student in his laboratory work. An appendix has been added, giving the chemical basis of the animal body, which is an interesting addendum to a useful and elaborate treatise. The volume is produced by the publishers in a most excellent form, and deserves to rank among the handsomest issues from this famous publishing house.

INTERNATIONAL CLINICS: A Quarterly of Clinical Lectures on Medicine, Surgery, Gynecology, Pediatrics, Neurology, Dermatology Laryngology, Ophthalmology, and Otology. By Professors and Lecturers in the leading Medical Colleges of the United States, Great Britain, and Canada. Edited by JOHN M. KEATING, M. D., Philadelphia, Consulting Physician for the Diseases of Women to St. Agnes' Hospital, Philadelphia; Editor Cyclopedia of Diseases of Children.—J. P. Crozer Griffith, M. D., Philadelphia, Clinical Professor of Diseases of Children in the University of Pennsylvania; Professor of Clinical Medicine in the Philadelphia Polyclinic.—J. Mitchell Bruce, M. D., F. R. C. P., London, England; Physician and Lecturer on Therapeutics at the Charing Cross Hospital; and David W. Finlay, M. D., F. R. C. P., London, England; Physician to the Middlesex Hospital, and to the Royal Hospital for the Diseases of the Chest; Lecturer on Clinical Medicine in the Middlesex Hospital Medical School. Large octavo. Pp. viii.—356. Illustrated. July, 1891. Philadelphia: J. B. Lippincott Company. 1891.

The second number of this series is even an improvement on the first, and it is full of interesting material, presented in a most readable form. Beginning with a biographical sketch of the late Dr. Joseph Leidy, accompanied with a full page portrait of this distinguished teacher and scientist, it goes on with its thirty-nine lectures by both American and foreign teachers, who are, for the most part, recognized authority on the subjects that they deal with. Among the titles we may mention the Pathology of Angina Pectoris, by Ernest Sansom, M. D., of London; Chronic Diffuse Nephritis, by James Tyson, M. D., of Philadelphia; The Treatment of Displacements and Flexions of the Uterus, by Egbert H. Grandin, M. D., of New York; Myoma, Complicating Pregnancy, etc., by Paul F. Mundé, M. D., of New York; Effects of Double Ovariotomy and Oophorectomy on the Secondary Sexual Characters of Women, by J. Bland Sutton, F. R. C. S., of London; Fracture of the Spine, Operation and Recovery, by M. Allen Starr, of New York; Peripheral Nervous System, etc., by James J. Putnam, of Boston; Acute Inflammation of the Middle Ear, by Charles H. Burnett, of Philadelphia. We have picked out at random some of the most important of these lectures, to give our readers an idea of their general scope and import; they are of value and of interest, and will well repay careful perusal. We consider this series of clinics a valuable addition to the literature of medicine, the publishers having put them out in excellent manner.

Medical Symbolism, in connection with Historical Studies in the Arts of Healing and Hygiene. Illustrated. By Thomas S. Sozinskey, M. D., Ph. D., author of The Culture of Beauty, etc. Physician's and Student's Ready Reference Series, No. 9. Pp. 171. Philadelphia and London: F. A. Davis, publisher. 1891.

To the practitioner who has no time or regard for matters not strictly practical, this little work would mean nothing; but to him who wishes to understand not only the essentials but also the non-essentials of medicine,—and these latter go far toward making a cultivated physician,—we can heartily commend this work. To an intelligent body of men, the history of medicine and medical mythology should be well known. How many of us know the meaning of the symbol written many times daily at the head of a prescription? The author says it is an "obsolete talisman."

The original form of it appears to have been a figure like a Z, with the lower horizontal part crossed with a scepter-shaped line. This, or a modification of it, has been from time immemorial the symbol of the planet Jupiter. Hence the reason for placing it at the head of prescriptions; for the great planet was believed in other days to have a favorable influence over diseases.

The medical symbols of recent times are fully explained: the physician's gold-headed cane, gold ring, the pentacle, etc., etc.,—all in all making a pleasant and instructive hour's reading.

Innumerable references are given to prove the author's assertions and deductions, and the result is an interesting and entertaining essay. W. C. K.

The Principles of Bacteriology: A Practical Manual for Students and Physicians. By A. C. Abbott, M. D., First Assistant, Laboratory of Hygiene, University of Pennsylvania. Philadelphia. With illustrations. Pp. 263. Philadelphia: Lea Brothers & Co. 1892.

The study of bacteriology must be a rapid-growing one, judging from the continual ripening of text-books on the subject. The discovery of new facts and new pathogenic organisms, no doubt, are in part accountable, because even this admirable little treatise, published in 1892, contains no account of the latest acquisition to our collection. This work is intended for laboratory students and "practitioners of medicine," but we doubt very much whether practitioners pay much attention to practical bacteriology. The scope of the work is excellent and very practical, serving as a guide for students at work in a laboratory. The description of the

various methods, apparatus, media, and the different genera are careful and painstaking, which, aided by well-executed engravings, makes it a desirable little book to possess.

Lea Brothers & Co. have clothed it nicely, as is their custom.

W. C. K.

PUBLIC LEDGER ALMANAC FOR 1892. George W. Childs, Publisher. Philadelphia.

This convenient little book contains a complete calendar for 1892, and a record of the important events of the past year in Philadelphia; also a list of the churches and public buildings of that city. Among other valuable items of information is a list of prominent government officials at Washington, an army and navy record, and a record of the census. Very seldom has so much desirable information been condensed into so small a space, and the generosity of the publisher in furnishing such a useful book free of cost is unexampled.

Miscellany.

THE PAN-AMERICAN MEDICAL CONGRESS.

Circular of Information. [*Official.*]

THE Committee on Permanent Organization met at St. Louis, October 14, 15, and 16, 1891, and adopted a series of General Regulations for the permanent organization of the Pan-American Medical Congress, and a series of Special Regulations for the government of the first meeting, and recommended that the incorporators adopt both series of regulations as the organic law of the Congress.

Pursuant to such regulations, the following general officers were elected, viz.: William Pepper, M. D., LL. D., Philadelphia, Pa., *President;* Abraham M. Owen, A. M., M. D., Evansville, Ind., *Treasurer;* Charles A. L. Reed, M. D., Cincinnati, Ohio, *Secretary-General.*

INTERNATIONAL EXECUTIVE COMMITTEE—*Argentine*, Dr. Pedro Lagleyze; *Bolivia*, Emilio de Tomassi; *Brazil*, Dr. Carlos Costa; *British North America*, Dr. James F. W. Ross; *British West Indies*, Dr. James A. De Wolf; *Chili*, Dr. Moises Amaral; *Colombia*, P. M. Ibañez; *Costa Rica*, Dr. D. Nuñez; *Ecuador*, Dr. Ricardo Cucalon; *Guatemala*, Dr. José Monteris; *Haiti*, Dr. D.

Lamothe; *Hawaii*, ————————; *Spanish Honduras*, Dr. George Bernhardt; *Mexico*, Dr. Thomas Noriéga; *Nicaragua*, Dr. Juan I. Urtecho; *Paraguay*, ————————; *Peru*, Dr. José Cassamira Ulloa; *Salvador*, Dr. David J. Guzman; *Santo Domingo*, ————; *Spanish West Indies*, Dr. Juan Santos Fernandez; *United States*, Dr. A. Vander Veer; *Uruguay*, Dr. Jacinto De Leon; *Venezuela*, Dr. Elias Roderiguez; *Danish, Dutch, and French West Indies*, —.

The Auxiliary Committee, nominated by the various members of the Committee on Permanent Organization each for his own State, and already commissioned by the Chairman, was confirmed.

The election of officers of sections was begun, but time would not permit of the completion of the list, which was referred to a special committee with power to act. It has been deemed inexpedient to publish the list until it is completed, which can hardly be accomplished before the meeting of the Committee on Permanent Organization, at Detroit, in June; but the organization of particular sections will be announced through the medical press as rapidly as officers are elected by the special committee.

In accordance with the wish of the Committee on Permanent Organization, as expressed in Special Regulation No. 4, Drs. I. N. Love, A. B. Richardson, L. S. McMurtry, R. B. Hall, T. V. Fitzpatrick, and Charles A. L. Reed met in Cincinnati and signed the legal form of application for articles of incorporation of the Pan-American Medical Congress, which Articles of Incorporation were duly issued by the Secretary of the State of Ohio, under date of March 15, A. D. 1892.

At a meeting of the Incorporators, held March 16, 1892, the following regulations, general and special, recommended by the Committee on Permanent Organization, were formally adopted as the organic law of the Pan-American Medical Congress in accordance with the Laws of Ohio, and all elections had by the Committee on Permanent Organization, in accordance with such regulations, were confirmed and made a part of the laws of the Congress:

General Regulations.

TITLE.

1. This organization shall be known as the Pan-American Medical Congress, and shall meet once in —— years.

MEMBERSHIP.

2. Members of the Congress shall consist of such members of the medical profession of the Western Hemisphere, including the West Indies and Hawaii, as shall comply with the special regula-

tions regarding registration, or who shall render service to the Congress in the capacity of Foreign Officers.

OFFICERS.

3. The Executive Officers of the Congress shall be residents of the country in which the Congress shall be held, and shall consist of one President, such Vice-Presidents as may be determined by special regulations, one Treasurer, one Secretary-General, and one Presiding Officer and necessary Secretaries for each section, all of whom shall be elected by the Committee on Organization, and there shall be such Foreign Vice-Presidents, Secretaries, and Auxiliary Committees as are hereinafter designated.

THE COMMITTEE ON ORGANIZATION.

4. The Committee on Organization shall be appointed by the representative medical association of the country in which the Congress shall meet. This Committee shall select all domestic officers of the Congress, and shall at its discretion confirm all nominations by members of the International Executive Committee, and in the event that any member of the International Executive Committee shall fail to nominate by the time specified by special regulation, the Committee on Organization shall elect officers for the country thus delinquent. It may appoint Vice-Presidents and Auxiliary Committeemen in foreign countries independently of nominations by the members of the International Executive Committee. It shall appoint Auxiliary Committees, arrange for the meeting, and frame special regulations for the session of Congress for which it was appointed. It shall make a report of its transactions to the opening session of the Congress.

THE INTERNATIONAL EXECUTIVE COMMITTEE.

5. There shall be an International Executive Committee, which shall be appointed by the first Committee on Organization, and which shall consist of one member for each constituent country. This Committee shall hold permanent tenure of office, except that when a member shall fail to be present at a meeting of the Congress, his office shall be declared vacant and the vacancy be filled by election held by the registered members from the country from which he was accredited. In the event of no representation whatever from the country in question, the members of the International Executive Committee present shall determine what disposition shall be made of the office.

It shall be the duty of each member of the International Executive Committee to nominate from the medical profession of his country, one Vice-President for the Congress and one Secretary for each Section of the Congress, and to forward the same to the Chairman of the Committee on Organization; except that in any country in which the Congress shall meet, it shall be the duty of the member of the International Executive Committee for that country to request his representative national medical association to appoint a Committee on Organization, which Committee on Organization

shall discharge the duties designated in Regulation IV. Members of the International Executive Committee shall also nominate such Auxiliary Committees, and shall furnish such information as the Committee on Organization may request.

6. The Committee on Organization may at its discretion cause the Congress to be incorporated, which incorporation shall hold only until the final disbursement of funds for the session held in that particular country. In the event of such incorporation, such officers shall be elected and in such manner as may be required by law.

7. The following shall be considered as the constituent countries of the Pan-American Medical Congress:

Argentine Republic, Bolivia, Brazil, British North America, British West Indies (including B. Honduras), Chili, Honduras (Sp.), Mexico, Nicaragua, Paraguay, Peru, Salvador, Colombia, Costa Rica, Ecuador, Guatemala, Haiti, Hawaiian Islands, Santo Domingo, Spanish West Indies, United States, Uruguay, Venezuela, Danish, Dutch, and French West Indies.

8. The Sections of the Congress shall be as follows:

(1) General Medicine, (2) General Surgery, (3) Military Medicine and Surgery, (4) Obstetrics, (5) Gynecology and Abdominal Surgery, (6) Therapeutics, (7) Anatomy, (8) Physiology, (9) Diseases of Children, (10) Pathology, (11) Ophthalmology, (12) Laryngology and Rhinology, (13) Otology, (14) Dermatology and Syphilography, (15) General Hygiene and Demography, (16) Marine Hygiene and Quarantine, (17) Orthopedics, (18) Diseases of the Mind and Nervous System, (19) Oral and Dental Surgery, (20) Medical Pedagogics, (21) Medical Jurisprudence.

LANGUAGES.

9. The languages of the Congress shall be Spanish, French, Portuguese, and English.

AUXILIARY COMMITTEES.

10. The Auxiliary Committee shall consist of one member for each medical society or one for each considerable center of population in each of the constituent countries of the Congress. Nominations for the Foreign Auxiliary Committee shall be made to the Chairman of the Committee on Organization by the members of the International Executive Committee, each for his own country, except that in the country in which the Congress is to be held nominations shall be made by the Committee on Organization. Appointments on the Auxiliary Committee shall hold only for the meeting for which they were made.

Members of the Auxiliary Committee shall be the official representatives of the Congress in their respective localities. It shall also be their duty:

(1) To transmit to the profession of their respective districts all information relative to the Congress forwarded to them for that purpose by the general officers.

(2) To coöperate with the officers of sections in securing desirable contributions to the proceedings of the Congress.

(3) To furnish to the general officers such information as they may request for the purpose of promoting the interests of the Congress.

(4) To cause such publicity to be given of the development of the organization as will elicit the interest of the profession and secure attendance upon the meeting, and they shall discharge such other duties as will promote the welfare of the Congress.

Special Regulations of the first Congress.

TIME AND PLACE OF MEETING.

1. The first Pan-American Medical Congress shall be held in the City of Washington, D. C., September 5, 6, 7, and 8, A. D. 1893.

REGISTRATION.

2. The Registration fee shall be $10.00 for members residing in the United States, but no fee shall be charged to foreign members. Each registered member shall receive a card of membership and be furnished a set of the transactions.

ABSTRACTS, PAPERS AND DISCUSSIONS.

3. Contributors are required to forward abstracts of their papers, not to exceed 600 words each, to be in the hands of the Secretary-General not later than the 10th of July, 1893. These abstracts shall be translated into English, French, Spanish, and Portuguese, and shall be published in advance of the meeting for the convenience of the Congress, and no paper shall be placed upon the programme which has not been thus presented by abstract. Papers and discussions will be printed in the language in which they may be presented. All papers read in the Sections shall be surrendered to the Secretaries of the Sections; all addresses read in the General Session shall be surrendered to the Secretary-General as soon as read; and all discussions shall be at once reduced to writing by the participants.

INCORPORATION.

4. The Chairman of the Committee on Organization shall cause the Congress to be incorporated under the laws of Ohio, and fifteen trustees shall be elected in accordance therewith, who by-laws and through the Executive Committee shall supervise all receipts and disbursements by the Treasurer in accordance with the laws of Ohio. The President, Secretary-General, Treasurer, the member of the International Executive Committee for the United States, and Chairmen of Sections, shall be *ex-officio* members of the Board of Trustees.

FOREIGN NOMINATIONS.

5. All nominations by the International Executive Committee must be in the hands of the Chairman of the Committee on Organ-

ization by June 1, 1892, and in default thereof the Committee on Organization shall elect officers for countries thus delinquent.

THE ORGANIZATION OF SECTIONS.

6. The officers of each section shall consist of —— Honorary Chairmen, who shall be residents of the constituent countries of the Congress; one Executive Chairman, who shall organize the work of the Section, direct its deliberations, and deliver an inaugural address at its opening session; one English-speaking Secretary and one Spanish-speaking Secretary, residents of the United States, who shall coöperate with the Executive Chairman in conducting the correspondence of the Section; and there shall be one secretary for each section, resident in each additional constituent country of the Congress.

DOMESTIC AUXILIARY COMMITTEE.

7. The Auxiliary Committee for the United States shall be elected by the Committee on Organization, and shall consist of one member for each local medical society, or, in the absence of medical organization, then one in each considerable center of population, which Auxiliary Committee shall coöperate with the Committee on Organization and with the General Officers in promoting the welfare of the Congress. Nominations for the Auxiliary Committee shall be made by members of the Committee on Organization, each for his own State, except that in the failure of any member to make such nomination by January 1, 1893, or in the inadequacy of the same, the Chairman of the Committee on Organization shall supply the deficiency.

EXECUTIVE COMMITTEE.

8. The Board of Trustees shall designate seven members, including the President, Treasurer, Secretary-General, and member of the International Executive Committee for the United States, who shall comprise an Executive Committee which shall transact all business of the Congress *ad interim* in accordance with By-laws adopted by the Board of Trustees.

AMENDMENTS.

9. Amendments to these Regulations can be made only by the International Executive Committee on a majority vote, ten members constituting a quorum, at any meeting of the Congress.

Pursuant to the Laws of Ohio and the Regulations adopted as above, and in accordance with nominations by the Committee on Permanent Organization, the Incorporators elected fifteen Trustees, as follows:

Dr. W. T. Briggs, Tennessee; Dr. Geo. F. Shrady, New York; Dr. P. O. Hooper, Arkansas; Dr. S. S. Adams, D. C., Dr. H. O. Marcy, Massachusetts; Dr. J. F. Kennedy, Iowa; Dr. H. T. Holton, Vermont; Dr. L. S. McMurtry, Kentucky; Dr. N. S. Davis,

Illinois; Dr. Levi Cooper Lane, California; Dr. I. N. Love, Missouri; Dr. Hunter McGuire, Virginia; Dr. J. C. Culbertson, Illinois; Dr. A. Walter Suiter, New York; Dr. C. H. Mastin, Alabama.

Drs. L. S. McMurtry (Ky.), I. N. Love (Mo.), and W. W. Potter (N. Y.) were designated to act as members of the Executive Committee.

The organization of the Congress is complete in British North America, the British West Indies, the Spanish West Indies, Guatemala, Nicaragua, United States of Colombia, Brazil, Uruguay, Venezuela and the Argentine. It is confidently expected that the nominations from the remaining countries will be in by June.

It is expected to announce the completed organization of the Congress, its sections and auxiliary committees, domestic and foreign, by July 1, 1892.

On behalf of the Committee on Permanent Organization,

CHARLES A. L. REED, *Chairman.*

J. W. CARHART, *Secretary.*

CINCINNATI, March 17, 1892.

SOUTHERN PINES, Moore county, N. C., is located on the highest sand ridge in the South. It has the driest climate, and the greatest amount of ozone is guaranteed by the forests of long-leaf pine which covers a territory of fifty miles in each direction.

Last year a delegation of Northern physicians was invited to examine and report on the place as to its adaptability for those suffering with throat and lung troubles. The delegation reported, through Dr. W. C. Wile, of Danbury, Conn., editor of the *New England Medical Journal.* At the end of the report the doctor says: "In conclusion, I am satisfied that Southern Pines possesses more of the qualifications of a genuine health resort, especially for those who are afflicted with pulmonary diseases and all of those of the air-passages, than any other place with which I am acquainted or have read about." With such information, we advise our readers who desire to send consumptive patients South, to make further investigation, for we have every reason to believe that Southern Pines must be a very desirable Winter resort. Hon. J. T. Patrick, Secretary of the Southern Bureau of Information, can give reliable information. His office is at Raleigh, N. C., which is near Southern Pines. It is Mr. Patrick's special business to furnish information of the South to those seeking it. What he says can be relied on

Messrs. P. Blakiston & Co., publishers, 1012 Walnut street, Philadelphia, announce that they have just ready from the press the following works, viz.: A Treatise on Diseases of the Lungs and Pleuræ, by the late Dr. Wilson Fox, F. R. S. P., Physician-in-Ordinary to Her Majesty the Queen. This book will consist of 1,200 octavo pages, with illustrations, and will be furnished in cloth at the net price of $8.00, prepaid to any address. Subscriptions should be sent direct to the publishers.

Also the following : Diseases of the Throat, Nose and Ear, with thirty-eight handsome colored illustrations printed in the text. A clinical manual for students and practitioners, by P. McBride, M. D., F. R. C. P., Edin., Fellow of the Royal Society, Surgeon to Ear and Throat Department of Royal Infirmary, Edinburgh, etc. In this work it has been the author's aim, while omitting nothing of importance, to so apportion the space as to attain the greatest usefulness to the general practitioner. To this end common diseases have been discussed at greater length, and the purpose preserved throughout of bringing the main and modern facts within a volume of reasonable dimensions. Special attention is requested to the method and quality of illustration by colored lithographs. These are all original, and most of them were drawn by Mr. J. Bayne from patients of the author. The fine execution of these drawings, under the direct superintendence of Drs. Semon and G. H. Mackenzie, is in full keeping with the new and comprehensive character of the book.

The Pope Manufacturing Co., 221 Columbus avenue, Boston, Mass., offers 100 prizes on the subject of good roads. These 100 prizes consist of an equal number of Columbia Bicycles to be distributed among the authors of the best published essays on the subject which we named. Each essay must not be less than 500 words in length, and it must be published in some paper or magazine between now and the first of May. All competing essays must be sent to the above address. Further instructions will be given upon application to the Pope Manufacturing Co.

Notice to Contributors.—We are glad to receive contributions from every one who knows anything of interest to the profession. Articles designed for publication in the Journal should be handed in before the first day of the month. The Editors are not responsible for the views or opinions of contributors. All communications should be addressed to the Managing Editor, 284 Franklin St., Buffalo, N. Y.

Buffalo Medical and Surgical Journal

Vol. XXXI. MAY, 1892. No. 10.

Original Communications.

THE OPERATIVE TREATMENT OF RETRO-DISPLACEMENTS OF THE UTERUS.[1]

By C. C. FREDERICK, B. S., M. D.,

Adjunct Professor of Obstetrics, Medical Department, Niagara University; Obstetrician and Gynecologist Buffalo Women's Hospital.

It is but a few years ago that most of the various ills of woman were ascribed to a displaced uterus. Fortunately a great deal of this belief has given place to a more correct pathology and a consequent more correct treatment. One of the malpositions, viz., retro-displacements of the uterus, none of you will deny, holds an important position in its influence on the health and well-being of women. In support of this statement could be cited the histories of many cases in which immediate or gradual relief to local and constitutional symptoms, has followed the replacement of a retroverted uterus and the introduction of a properly fitting pessary.

The majority of women having retroversion have also uterine hypertrophy, catarrh, and sterility. If conception does occur, the retro-displacement is frequently the cause of much trouble in the early months of pregnancy, such as excessive vomiting, frequent and painful micturition, polyuria, and abortion. I have seen complete retention of urine at the third and fourth months of pregnancy, due to this displacement. Today I have been obliged to induce abortion, the patient being two and one-half months pregnant. She had a retroverted adherent uterus which could not be replaced; the vomiting was excessive and exhausting nearly to the point of collapse. Before she had the pelvic peritonitis which bound down her uterus and its appendages, she carried her children with less nausea than most women experience. We, therefore, probably, do not over-estimate its importance in the causation of distressing symptoms.

1. Read before the Buffalo Obstetrical Society.

Backward displacements requiring operative treatment fall into either of the two classes :

1. Those which cannot be held up by pessaries when replaced.

2. Those which cannot be replaced because either the uterus or the appendages are adherent from previous pelvic inflammation

To the first class belong those associated with or caused by lacerations of either cervix or perineum, or both ; in which case pessaries will probably fall out of the vagina, or will sag to a sufficient degree to allow the uterus to tip backward. Repair of the lacerations, which corrects the subinvolution of the uterus and restores the retentive power of the vagina, makes it possible to correct the displacement, unless there be a prolapse of one or both of the ovaries. A prolapsed ovary, whether it be adherent or not, if it is not possible to get it out of the way so as to avoid its being pressed upon by the pessary, is an effective barrier to the efficient use of this support. Therefore, any retroversion causing distress, if associated with lacerations of the cervix or perineum, should first be subjected to repair of the lacerations. If lacerations complicate those cases in which there has been pelvic inflammations with adhesions, the repair of the lacerations may be one step in the right direction, but this will not free the uterus and allow of its restoration to normal position. To do this, some operative method must be sought.

Since abdominal surgery has reached its present stage of development, there have been devised several methods of treating successfully all those cases which formerly were irremediable.

The first was Alexander's operation, which, as you know, consists in shortening the round ligaments, by cutting down upon them as they emerge from the inguinal canal, and pulling them out far enough to raise the uterus to the required position, and stitching them into the wound. Alexander's operation has never met with general favor. It is applicable to but a limited class of cases. Patients subjected to it have been reported, in many instances, as suffering as much pain after operation as before, from the pulling in the scar. I have now under my care a young woman who has had this operation done by a Western surgeon with no benefit, as she is obliged to wear a retroversion pessary. Without the pessary, she complains of pain throughout the pelvis, probably caused by traction on the round ligaments.

The operations which have met with most success are some forms of ventral fixation of the uterus, or shortening of the round

ligaments by laparatomy. There are several methods of ventral fixation, dependent upon the condition of the uterus and its appendages. If there is no disease of the tubes or ovaries, nothing to remove, the fundus uteri may be denuded of epithelium by scraping it with a scalpel, and two or three of the stitches in the lower end of the incision passed through the fundus, thus drawing it up against the abdominal wall, where it will adhere and remain after the stitches are removed.

The round ligaments may be shortened by Wylie's method. The uterus is lifted into normal position, and the slack in the round ligaments taken up by lapping a fold of each upon itself and stitching it. Dr. A. P. Dudley shortens the round ligament by passing a stitch beneath it at any distance from the uterus estimated as necessary. He then passes the thread through the fundus, which has previously been denuded of a small patch of epithelium, thence the thread is carried beneath the opposite round ligament, at the same distance from the uterus as the first stitch. When the silk is tied, the ligaments are shortened and approximated to the fundus, where they adhere. They also have a longer leverage upon the uterus than before.

Dr. Polk and Dr. Howard Kelly have each reported modifications of the intra-abdominal fixation methods which they have used.

If the appendages are removed, their stumps may be sewed to the abdominal wall, or a stitch passed through the fundus, as before described. The latter method I have done. I have had no experience with Dr. Dudley's method, but, on theoretical grounds, and from the reported experiences of others, I believe it to be the best method yet devised.

A uterus found retroverted during laparatomy should always be brought forward and secured by some one of these various methods. Even when the tubes and ovaries are removed, a retroverted uterus may give trouble, although we would expect that atrophy of the organ following this operation would forever prevent its causing any further disturbance. The experience of the oldest operators will coincide with this statement.

While in Europe recently, I saw several methods, both intra-abdominal and vaginal, in course of trial. Most of the vaginal methods seemed to me unsurgical, several of them requiring the peritoneal cavity to be opened through Douglas's cul-de-sac, to break up adhesions, before resorting to the fixation. The intra-abdominal

plan is most direct and surgical, and such seemed to be the opinion of all the best operators whom I saw.

The question naturally arises, What will be the effect upon a subsequent pregnancy if the uterus is sewed to the anterior abdominal wall? The same question cannot be raised when only intraperitoneal shortening of the round ligaments has been done. Ventral fixation is more used in Europe than any other method. Martin, Leopold, and Olshausen told me of pregnancies going on subsequent to the operation as though no fixation had been made. Furthermore, Leopold told me that he had examined three women who had borne children after operation, and the uterus in each case was in position. This same fact is observed in all Cesarean sections done more than once upon the same woman. I saw Leopold do one Cesarean section, it being the second the woman had had, and another which was the third the woman had undergone. In both of these there was extensive adhesions all along the line of the old uterine and abdominal incisions, and they had not interfered in the least with the course of pregnancy.

The points to which I wish to call your especial attention are:

1. That retroversions caused by or aggravated by accompanying lacerations of cervix or perineum, should have the lacerations closed to insure relief and reposition.

2. A uterus or appendage bound down posteriorly cannot be raised, nor the adhesions broken up manually through the rectum or vagina, unless they be very recent or slight. They must be broken up by laparatomy and the uterus restored and retained in position by some one of the many plans now used.

3. No malposition of the uterus needs operative treatment unless it renders the woman sterile or causes her physical suffering or inconvenience. Those whose condition demands relief should be given the benefit of some of these various methods which have been proven safe and efficient.

64 Richmond Avenue.

Lactation and Pregnancy.—Dr. Lewellyn Eliot, of this city, discussed Dr. Walsh's paper and spoke of the "popular fallacy" among women, that so long as they are nursing a baby there is no danger of their becoming pregnant. Dr. Eliot also stated that the amount of nourishment in breast-milk, after the tenth month, was no greater than in ordinary beef-tea.—*National Medical Review.*

SOME CONTRA-INDICATIONS FOR THE USE OF OPIATES.[1]

By MARIE B. WERNER, M. D., Philadelphia.

My object in presenting this subject before the society tonight is manifold. I wish to show that in general practice the indications for the use of opiates are limited. We must fully realize that we have a broader basis for medical science than symptomatology, in order to give our patients the full benefit of our knowledge.

Our position being at all times one of trust, we must endeavor, in helping our patient, to find the cause and remove it, rather than hide the symptoms it gives rise to, by an opiate. Aside from the possible mental disturbances such a course of treatment might induce, it often materially complicates surgical efforts to relieve patients, the results of which we have repeatedly heard discussed at these meetings.

In order to discuss this drug with due fairness, it will be necessary to give a few moments to the consideration of its physiological action on the human economy. Prof. Wood, in his Treatise on Therapeutics, says:

When opium is taken in such a dose as to produce its mildest physiological effects, it exerts a quieting influence, inducing a peculiar dreamy condition. After a length of time, varying according to the idiosyncrasies of the patient and the dose of the drug, this condition passes into sleep, either light, dreamful, natural, or heavy and deepening into stupor. On awakening, the patient may return at once to his normal condition; but very often he experiences a state of depression, shown by languor, a little headache, nausea, or even vomiting, which may last for some hours. One of the most common of these departures from the ordinary course of symptoms, is an excessive depression following the sleep produced by moderate doses of the medicine. This state is seen, so far as my experience goes, most usually in females of weak, nervous organization, such as are peculiarly liable to attacks of neuralgia. The symptoms are a feeling of weakness and prostration, often accompanied by chilliness, dull headache, and giddiness, but especially marked by intense nausea and frequent vomiting.

Bartholow states that, as a rule, opium does harm in all gastro-intestinal maladies in which there is a deficiency in the proper secretion, or a suspension of the functions of the liver and the kidneys.

Dr. J. B. Mattison, in his valuable paper read before this society in October, 1890, entitled The Renal Status of Opium Habitues,[2]

1. Read before the Philadelphia County Medical Society, January 27, 1892.
2. Buffalo Medical and Surgical Journal, Vol. XXX., p. 332.

arrived at the following conclusions, after a careful analysis: First—The habitual use of opium, in any form, will cause organic renal disease. Second—The changes most likely to be met with are cirrhotic. Third—The rationale is threefold,—vasomotor changes, impaired general nutrition, and inflammatory action, due to non-eliminated irritant products. I would further call attention to the valuable contributions of Dr. A. Haig, published in the *British Medical Journal*, 1890. In his studies on the influence of opium and morphia on uric acid, also of the retention of this latter product in the human economy and its relation to the causes of disease, his observations and experiments proved to him that the administration of opium or morphia caused retention of uric acid accompanied by a reduction of arterial tension; that when the effect passes off there is a rebound with excessive excretion of uric acid and marked high tension, often accompanied by headache and mental depression.

Let us look carefully into these statements and compare them with our practical experience; we find that after lulling pain and induction of sleep, we come to a period of depression, even after a moderate dose of the drug. This depression is usually followed by a certain loss of resistance to bear any renewal of pain, and, in consequence, it becomes necessary to repeat the use of the drug. Indeed, when we study carefully its action on a previously weak, nervous organization, we find that the description given by Prof. Wood very ably describes the case for us. He tells us: "The symptoms are a feeling of weakness, prostration, chilliness, dull headache, nausea, etc." In the face of this, the questions must certainly present themselves to us: Is it wise to simply gratify the desire of the patient? Would it not be better to study the cause and remove it, rather than hide the symptoms which lead us to the origin of the trouble? I refer to cases in everyday practice, cases in which a periodical monthly pain is lulled to sleep by several doses of morphia or opium, while the proper cause is entirely left out of sight. There is no doubt in my mind that many instances have come to all of us where a case of chronic constipation or continuous indigestion combined with a nervous, irritable temperament, perhaps added to that, or independent of this, an unpleasant skin eruption, etc., claimed our attention.

Quite often a question regarding any menstrual difficulties shows that there is some pain, often varying in severity, and the next question, What do you do for the pain? will often elicit the

answer: Oh, I take a little paregoric, or, I have some pills or suppositories I use; perhaps previously given to some member of the family for pain. Not infrequently an investigation will show that the main ingredient is some opiate.

In our day of progressive medical science, it becomes necessary that we should join hands and forces, first to see if the proper hygienic rules regarding clothing, exercise, and cleanliness are scrupulously carried out, and that the proper functions of secretion and excretion are thoroughly understood. If, aside from these precautions, there is still pain, a local investigation should be made by the physician, the condition carefully studied, and the cause removed if possible. To give an opiate in such cases I consider criminal, since the patient receives a double injury: not only is she not relieved permanently, but she is robbed of much of her normal resistance, and I fear many have become chronic invalids: for it is a constant struggle to overcome the after-effects of the opiate before the time arrives for another relief of the same sort. If the patient escapes becoming addicted to the opium habit, she cannot escape the local gastro-intestinal irritation, which is invariably set up, and which will defy all medication so long as its cause remains.

I can at this moment call to mind three cases in which, three weeks out of four, all sorts of laxatives are used to overcome the amount of morphia taken during the fourth week. The complexion is sallow, the breath heavy, and the skin impure: and how can it be otherwise? If an examination reveals no functional trouble other than the local congestion, or possibly some displacement downward, induced by improper clothing or a lack of attention to the proper secretions, is it not at once clear that an opiate, in the long run, increases the cause of pain? Lulling pain induces no cure, and the resulting constipation acts in two ways to make the patient worse: (1) The pressure of a distended bowel. (2) The absorption of effete products. Let such conditions continue for some years, as they often do, and we have other factors entering the field to make life miserable,—sluggishly acting liver or kidneys, a wornout stomach, and not infrequently a nervous wreck.

In order to emphasize this point, I shall only have to call attention to a series of comparative experiments on animals made by Dr. Edward Levinstein, and reported in his book on Morbid Craving for Morphia. His deductions from a number of experiments are as follows:

1 Covering a space of time from [illegible]

1. That internal application of morphia sooner paralyses the digestive powers of the stomach than the subcutaneous injection.

2. Both ways of administering morphia bring on functional disorders of the secreting nerves.

3. Both cause catarrh of the stomach and intestinal tract.

4. Large doses of morphia given internally cause a subacute catarrh of the stomach, on account of the irritating chemical action of the morphia.

5. The subcutaneous injection of morphia causes a chronic catarrh of the intestines in a mechanical manner. In consequence of the impaired influence of the secreting glands, due to the action of the morphia, the secretion of the digestive fluids is stopped altogether, or at least diminished in quantity, and consequently the intestinal tract is encumbered for a longer time by the ingesta.

The same author speaks of amenorrhea and sterility as being a sequence to the continued use of morphia, drawing largely upon the results of his own observations, and accepts Pflueger's theory in explanation of it.

In these days, when "preventive medicine" is being advocated by all of us who desire to place medical science on the highest standard, should we not think many times more than twice before we write a prescription for an opiate to relieve pain? In the face of all these facts, it becomes a serious question of right and wrong if we stop short of exerting all our knowledge to study the *cause* of the pain we have been called upon to alleviate. Often the prescription book is entirely useless, unless its blanks could be filled with directions to the patient how to dress, eat, and give herself the physical care she needs.

The use of morphia after pelvic operations has been discarded by most of our operators, and clearly has been the means of reducing mortality rates, as well as of obviating many of the dreaded after-complications. I recall, in one of my early operations, the advice given by one of our older physicians, to rely on opium and calomel, which I followed, with the result of having on my hands a sufferer from insomnia and chronic constipation after I had discontinued its use. Had I not been careful to destroy all prescriptions, I feel certain I would have had more trouble. Another case comes to my mind, of a patient who had a section done for some pelvic trouble, by a physician who also believed in the opium after-treatment. This patient came under my care later, and confessed that she had often helped herself to suppositories after the doctor had stopped their use. My object in referring to these cases is to

show the danger of setting up the morbid craving and its attendant evils, with only medicinal doses, and this in the space of two or three weeks, showing at once the danger a prescription containing an opiate may give rise to in the hands of a nervous patient who has periodical attacks of pain. Such cases do not always reach the state necessary to require hospital treatment, hence are often exceedingly vexing to the physician and surrounding friends. A direct accusation to the patient would often fail to bring the desired results, while the friends and relatives cannot always be relied upon for the tact and discretion so necessary. For that reason the physician must often exercise a vast amount of patience and time, to educate the ones immediately concerned and prove the deleterious effect the use of opiates has; and, *perhaps*, you can cure your patient!

It may, perhaps, be of interest to quote from a discussion on morphia in the British Gynecological Society, 1889. Dr. Bantock gave as his experience after surgical operations that patients were much better off without it,—they escaped the restlessness which was left as the opium wore off. Dr. Bedford Fenwick called attention to the fact that opium increased the congestion of the kidneys to a dangerous extent, and might even go to a complete suppression of urine; also, that it caused a complete atony or paralysis of the muscular tissue of the intestines, thus preventing their acting. Dr. R. T. Smith had given two doses of a quarter of a grain of morphia each in a case of severe shingles; the patient had suppression of urine for twenty-four hours. Dr. Thomas Savage, in his address read at the annual meeting of the Birmingham and Midland Counties branch of the British Medical Association, says:

> It is not long since it was the custom to administer opium and morphia as a routine treatment in all cases of peritonitis and any other conditions in the abdomen. We have now learnt the inadvisability of so doing. May we not extend the withholding of these and similar drugs in other states? I have myself thought that the general practitioners rely too much upon anodynes.

In this matter of too sympathetic and assiduous medical treatment, errors rather of judgment than intentional are often committed.

Of no less importance is the behavior of an opiate on a patient of uric acid diathesis, in which a demand for the relief of pain on the part of the patient often becomes urgent. Here again the researches of Dr. A. Haig shows us that the drug tends to store up

the acid, that when elimination begins to take place there is often a return of the pain, the patient again demanding relief; in this manner a cycle can easily become established. These pictures teach us the importance of keeping the drug *entirely out of the reach of the patient*, and the necessity of its *careful* and *conscientious* use where it may be indicated.

1010 CLINTON STREET.

Clinical Reports.

A "MUCH NERVOUS" CASE.[1]

BY WILLIAM C. KRAUSS, M. D., Buffalo, N. Y.

I BEG the members of this society to bear with the title of my paper until after its reading; then if any apology is necessary on my part, I will unhesitatingly comply. Moreover, my title stands as a challenge for any one to produce a more nervous case, but I hope, for humanity's sake, that none will be forthcoming.

The patient was referred to me by Dr. F., who desired to know what form of treatment would give the most relief.

Name, A. H.; female; *single*; occupation, seamstress; *age, forty-three*; height, four feet ten inches; weight, ninety-eight pounds; complexion, fair; hair, brown; constitution, frail and delicate; temperament, decidedly neurotic.

Antecedents.—She has no knowledge of her grandparents on the paternal side, while on the maternal side they reached old age, dying at ninety and eighty-four years respectively. Her father died of tuberculosis when sixty-eight years of age; her mother, still living, is of a highly nervous temperament, but not afflicted with any recognized nervous disease. The aunts and uncles on her mother's side are all subject to heart disease. She had one sister present at the examination, who suffers much from nervous headaches, is extremely irritable, and, in her own words, is "very nervous." One brother, a typesetter, belongs to the same category.

History.—When three years old she passed through a severe attack of scarlet fever, and at seven the whooping cough. She made good recoveries without any disagreeable sequelæ. At thirteen she was first afflicted with asthma, the paroxysms becoming very severe at times. At fourteen menstruation appeared, bringing with it a train of amenorrheic symptoms, compelling her to give up her schooling almost entirely.

1. Read before the Buffalo Clinical Society, April 9, 1892.

At sixteen, while watching her companions at play, she was forcibly pulled backwards, receiving an injury to her spine. She complained much of soreness and pain in her back, and was hardly able to walk or move about. Her general condition was very poor at this time and constantly growing worse until her twenty-third year, when she was obliged to keep her bed altogether. Symptoms of myelitis were present at this time, such as spasticity and sensory disturbances of the lower extremities and suppression of urine. To these symptoms were added new ones, more or less hysterical in nature—among others, convulsions, especially after excitement, etc. These attacks were of such frequent occurrence that she decided to try the hot pack treatment, which gave her considerable relief for a short time. Just as she was getting accustomed to bear her loads patiently, she noticed her neck swelling, her eyes bulging, and she experienced attacks of palpitation and flushings. These symptoms of exophthalmic goitre continued in their way for two years, the neck gradually growing larger. In 1880 her left arm began to trouble her. Sharp, shooting pains were felt extending from the shoulder to the tips of the fingers; at the same time it grew weaker and weaker until it was rendered almost powerless. In 1882, the right arm became similarly affected, though to a less degree. After a period of a few months the pain and weakness in the arms would diminish and she would regain partial control over them. Since 1880, the left arm has been helpless ten times, the right three times. In 1886, she had two severe attacks of gastralgia and cardialgia, and her life seemed to be in imminent peril. She rallied, however, and a short time thereafter underwent an operation for the removal of uterine polypi. Of late she has had no recurrence of the asthma.

Examination.—The patient, accompanied by her sister, was barely able to come to my office on account of the weakness of her limbs and shuffling gait. I found her a small, sickly-looking woman, possessed of a fair amount of intelligence, extremely anxious to secure some relief from her sufferings.

Her head, rather small, was well formed and regular, and disclosed neither scar nor deformity. The eyes were prominent, pupils symmetrical, field of vision normal on the left side, narrowed and amaurotic on the right. No actromatopsia. Sense of smell was diminished on the right side, sense of hearing also diminished on this side, while the sense of taste was unimpaired. She has been troubled many years with an obstinate nasal catarrh, and has suffered much from earache. She complained of difficulty in swallowing hoarseness, and a spasmodic cough, all due, no doubt, to the pressure of the goitre upon the larynx. Her neck was markedly increased in size, measuring thirteen and three-quarter inches in circumference. The left lobe of the thyroid gland was larger than the right, and extended well into the left supraclavicular region. The right lobe, though somewhat

smaller, extended into the right supraclavicular region. The gland was hard, firm, and dense, growing somewhat smaller and softer towards evening. On auscultation a bruit could be distinctly heard. She complained of sharp, shooting pains, especially on pressure over Erb's point on both sides, radiating to the tips of the fingers, to the shoulder, and along the occiput to the upper level of the ears. The muscles of the right arm were much atrophied, particularly those of the forearm and hand. The muscular force, as measured with the dynamometer, showed ten pounds. Trophic disturbances, such as hyperidrosis, glossy skin, etc., and disturbances of sensation, were also present. The left arm was even more affected than the right. The atrophy of the muscles was far advanced, the dynamometer giving but three pounds pressure. Trophic and sensory disturbances were also present similar to those on the right side. Pressure over the nerve trunks was exceedingly painful, and, when persisted in, the arms were thrown into a series of clonic contractions. The legs were weakened, paretic, the muscles soft and atrophied, the patellar reflexes exaggerated, ankle clonus present on both sides, and the gait spastic. The vesical reflex was impaired, retention of urine being the rule. The urine contained neither albumin nor sugar. The rectal reflex was normal. The general sensibility of the legs was somewhat blunted, trophic disturbances were wanting. An electrical examination of the arms and legs, for obvious reasons, could not be made. The body presented no noteworthy malformation. The spine was painful and tender to the touch, especially between the fourth and tenth dorsal vertebræ. The heart, somewhat enlarged, was rapid, pulse ninety-six, prone to palpitation, and on auscultation revealed a mitral engurgitant murmur. The other internal organs, as far as could be ascertained, were apparently healthy.

The history and examination of such a case furnishes almost material enough for a first-class clinic throughout a good part of the college year. Perhaps her occupation as seamstress is responsible for the snarl which the threads of disease have produced! To unravel it was a task by no means as easy as it may appear.

Her family history on the mother's side savors of a neurotic tendency, while on her father's side there appears to be a tubercular diathesis. I know of no combination so favorable for the transmission of hereditary disease. This is, then, briefly a story of her life. Scarlet fever at three, whooping cough at seven, asthma at fourteen, myelitis at tweny-three, exophthalmic goitre at thirty-five, pressure neuritis with paresis of the upper extremities at thirty-seven, gastralgia and cardialgia at thirty-nine, and hysteria dating back to the beginning of her menstrual periods. To these must be added such minor affections as amenorrhea, chronic nasal and aural catarrh, mitral disease and uterine polypi.

I advised a partial thyroidectomy as affording the most immediate relief, believing that the neuritis was dependent upon pressure of the goitre upon the cervical and brachial plexuses at their points of origin.

Translation.

CHLORINE WATER AS AN ANTISEPTIC IN OPERATIONS AND INJURIES OF THE EYE.

BY SCHMIDT RIMPLER, of Göttingen

Translated by ALVIN A. HUBBELL, M. D., from *Annales d'Oculistique*.

THE disinfecting power of officinal chlorine water (German Pharmacopeia) has been known a long time, and my experience was published in 1877, in Volume LXX. of *Virchow's Archives*. I made punctures in the cornea of rabbits with an instrument charged with the products of the secretion of chronic blennorrhagic dacryocystitis, which is a potent agent of suppuration. The germs were introduced by the aid of a needle into the puncture in the corneal tissue. Before the inoculation, the infectious liquid was brought under the influence of various disinfecting solutions, and the extent of the antiseptic effect was measured by the absence or modification of the corneal suppuration. The comparison between chlorine water, salicylic acid, phenic acid, thymol, and quinine has resulted in recognizing the chlorine water as the more potent antiseptic. Experiments since made have led to the same result. In placing cultures in contact with disinfectant solutions, Buchholz, Koch and his assistants, Sattler, Weeks, and others, have had occasion to notice the extraordinary antiseptic power of chlorine water. These two series of experiments mutually complete each other. It is not sufficient to ascertain the influence of antiseptics on the development of cultures, but it is necessary also to test their action on the products of the workings of microörganisms, especially on infected structure. The researches of Fischer and Proskauer[1] have shown that humidity, also, of the microörganisms plays an important role. Cultures soaked with water were surely and rapidly killed by the chlorine in relatively thick layers. In inoculating the *staphylococcus pyogenes aureus* into the cornea, I have observed that the sterilization was more rapid in cultures

1. Ueber die Desinfection mit Chlor. und Brom.. *Mittheilungen aus dem Kaiserl Gesundheitsamt*, Vol. II., 1884

emanating from liquified gelatine than in relatively dry cultures that were at the beginning of their development. The first ordinarily became sterile one minute or less in the chlorine water. It is proper, however, to consider that the intensity of the suppuration provoked by different cultures of *staphylococcus* varies. The influence of the chlorine water on the secretion of the lachrymal sac was also prompt, while that of solutions of bichloride, such as are applied in ophthalmology (1 to 5,000), were very inferior. The same culture of *staphylococcus pyogenes aureus* that became sterile after one minute in the chlorine water remained very virulent after three minutes in the bichloride solution. To render sterile the secretion of purulent inflammation of the lachrymal sac, it was necessary to allow five to ten minutes of contact with the bichloride solution, three to five minutes simply weakening its virulence. The experiments with pus from the lachrymal sac are much more decisive in ocular antisepsis, as it is the microbes from this that are more often the cause of operative suppurations of the cornea, and as the microbes exposed to the influence of antiseptics are in analogous conditions to those that provoke corneal suppurations. Notwithstanding its extraordinary bactericidal power, chlorine water has not been generally applied as an antiseptic in ocular operations.

Previous to the past year I applied it in isolated cases only, where the danger of an infection was imminent; for example, in operations on patients affected with dacryocystitis. Since that time it has served me as an antiseptic for all operations. I believe it proper to publish the observations collected on this subject, and to recommend, strongly, the employment of chlorine water in ophthalmology.

Up to the month of July of this year (1891), I have applied the chlorine water in 125 cases of extraction of cataract. Among the first twenty-five cases operated upon at Marburg there was one of primitive suppuration of the corneal wound. The lips of the wound illy adapted themselves to each other, and an alcoholic delirium necessitated a change of the dressing a short time after the operation. It is quite possible, therefore, that the infection was secondary. The 100 extractions made since then at Göttingen were without incident, as well as other operations to the number of 375, among which were several plastic operations.

The corneal infiltrations, provoked by the sublimate after the instillation of cocaine, do not occur with the application of chlo-

rine water, this, to my mind, constituting a considerable advantage. I will add that cocaine, in several operated upon, has produced extended superficial infiltrations and epithelial lesions that were increased by the manipulations necessary in the evacuation of the cortical remains of the lens. It was the same in the cases where the flap had been everted by the upper lid. These corneal infiltrations, due to the application of sublimate, compromise in an unpleasant manner the success of cataract operations, although preventing, almost absolutely, suppuration. Thus, Alfred Graefe,[1] who has made a very large use of this antiseptic substance, reports: "In 1,074 operated upon for cataract, suppuration occurred only in 0.93 per cent., but in 4.7 per cent. of the cases there was an inferior acuity of vision of one-ninth, on account of corneal infiltrations. The chlorine water prevents the suppurations without injuring the cornea.

There are two special objections to the general employment of chlorine water in traumatisms and operations on the eyes: the fear of too much irritation, and its tendency to undergo decomposition. I am convinced that these are not justified. Far from irritating the wound or conjunctiva, the chlorine water produces less conjunctival secretion than the sublimate. It causes a slight smarting of the eye that is unnoticeable under the cocaine anesthesia. It is hemostatic, and colors the blood cherry-red. In the second place, certain precautions suffice to prevent the chlorine water from decomposing. The flasks, closed by glass or rubber stoppers, should not exceed the capacity of 250 to 500 grammes (eight to sixteen ounces), and their contents excluded as much as possible from the influence of air and light, the two principal agents of its decomposition. I have found that the water in the bottom of a flask, whose contents have served during four weeks in the dispensary, still rendered sterile the secretion of the lachrymal sac. Analysis showed that it contained 0.23 per cent. of chlorine, instead of 0.4 per cent., which represents the proportion of the German pharmacopeia. Two cubic centimeters of chlorine water, which had remained eight days in a flask of 500 grammes, supplied three and a half weeks before, was always active. As long as the liquid presents the characteristic odor of chlorine, it may be applied. A more exact test is obtained by the use of litmus paper, which is bleached by the active chlorine water; the presence of hydrochloric acid is shown by the litmus paper changing to a reddish tint.

1. *Graefe's Archiv.*, Vol. XXXV., Part 3, 1889.

Concerning the question of price, it is proper to consider that the bactericidal power, so pronounced in the chlorine water, makes the application of large quantities unnecessary; 250 grammes, of which the price is one franc fifty centimes (twenty-seven cents), have sufficed for ten operations.

In plastic operations on the lids, and traumatisms of the eye, the results obtained with this substance have been as satisfying as those obtained in intraocular operations. In cases of corneal suppuration, especially in serpiginous ulcer, irrigations with it, repeated several times a day, have given me very satisfactory results, although operations may still be necessary in grave cases. In these, the operation of Sæmisch seems to me preferable to the application of the galvano-cautery.

The *modus faciendi* employed in operations is the following: The instruments are placed in a solution of phenic acid (1 to 20) for half an hour, and then put in alcohol. They are next immersed in phenic solution (1 to 40), and given to the operator without being dried. I believe them to be more antiseptic when wet, and the contact of the phenic acid with the incision favors, perhaps, primary union. The patient takes a bath before the operation, and the face is cleaned with soap. Shortly before the operation, and before the instillation of cocaine, the lids and their surroundings are washed with sublimate solution, and the conjunctival cul-de-sac and globe with chlorine water. During the instillation of the cocaine, the eye is kept covered with a muslin compress wet with chlorine water. When the patient is laid down, the cul-de-sac and globe are again irrigated with chlorine water, and the lids wiped off with muslin compresses moistened with the water. The irrigation is repeated when the operation is finished. The lids are then covered with muslin compresses wet with chlorine water and cotton sterilized with bichloride, and the whole is fixed by a sterilized bandage. The compresses wet with chlorine water are kept in an enameled jar, covered, to avoid as much as possible the inconveniences of the penetrating odor of the chlorine. The first dressing is kept on four days, when it is renewed in the same manner. If the skin is irritated, the dressing is replaced by a dry one of boracic gauze and sublimated cotton. The wet dressings require some precautions. I have seen abscess of the lids with suppuration of the cervical glands take place under dressings wet repeatedly with bichloride.

The good results obtained with the chlorine water in plastic

operations of the lids, healing taking place without any secretion, justifies methodical trials of this antiseptic in other branches of surgery.

Society Proceedings.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

SOME CASES OF OBSTRUCTIVE DISEASE OF THE LACHRYMAL PASSAGES AND THE ASSOCIATED INTRA-NASAL LESIONS.

By G. E. De SCHWEINITZ, M. D.,

Professor of Ophthalmology in the Philadelphia Polyclinic, Lecturer on Medical Ophthalmoscopy, University of Pennsylvania; Surgeon to the Philadelphia Hospital, etc.

[*Read March 28, 1892.*]

The intimate relationship between diseases of the lachrymal apparatus—that is, of the drainage system of the eye—and various types of inflammatory changes in the nasal mucous membrane is an old story. Indeed, the close association of ocular and naso-pharyngeal disease is not limited to these conditions. The great majority of phlyctenular ophthalmias depend upon some type of rhinitis, and are often the direct outcome of adenoid growths in the pharynx. Many obscure symptoms which we are wont to describe under the general term asthenopia, have been shown to depend upon intra-nasal disease, and a variety of orbital, ocular, and post-ocular pains are frequently "referred pains;" that is, their origin is from some lesion within the nasal cavity, the frontal sinus, ethmoid cells, or antrum of Highmore. In fact, as Harrison Allen has remarked, a good deal of the success of treatment depends upon a proper attention "to the commonality of the various parts of the cephalic mucous membrane."

The following cases are reported, not because they illustrate new points, but because they emphasize some old ones, and still more because they emphasize that the cure of obstructive lachrymal disease is materially facilitated not merely by the ordinary measures adopted for rendering the passages patent, in association with what may be called routine intra-nasal treatment, (for I take it no one attempts to treat lachrymal disease without due attention to the nasal mucous membrane,) but that more radical measures are frequently of value when applied to the nasal chambers and the

vault of the pharynx, which in the vast majority of cases are the regions primarily affected.

Case I. *Purulent dacryocystitis: traces of old rhinitis and abnormal shape of the lower turbinated bone.*—D. D., a boy aged seven years, reported for treatment November 3, 1890. Three years ago pus began to exude from the right punctum lachrymale, and in spite of treatment this condition has continued ever since. The boy was healthy in other respects; he had never suffered from measles nor scarlet fever; was free from the evidences of inherited syphilis, and had sustained no injury. His voice was slightly nasal in tone.

The lower canaliculus was slit, and a firm stricture was found at the beginning of the nasal duct. The probe was not forced; neither was the stricture incised.

The patient was referred to Dr. Alexander MacCoy for nasal examination, who reported as follows: "The right nostril shows an abnormal shape of the lower turbinated bone, also some evidence of a severe rhinitis during the past. I believe that the position and form of the lower turbinated body have had much to do with the disease of the duct on account of the obstruction to its entrance at its lowest portion into the nasal chamber. The boy also has a pharyngeal tonsil, which obstructs the posterior nares somewhat." Dr. MacCoy undertook the treatment of the nasal condition, and after a few days the stricture was incised, the probe passed, and the usual treatment instituted. After the intranasal obstruction was removed, the epiphora ceased and has not reappeared.

I have referred to this case in a paper on the use of pyoktanin in dacryocystitis, (*University Medical Magazine*, Vol. III., p. 181,) and may repeat that my colleague, Dr. Gould, as well as myself, has had favorable effects from this drug in the treatment of unhealthy lachrymal secretions.

The case is now utilized, however, to illustrate what seems to me a very important point to which Dr. MacCoy calls attention in his report, namely, that although the stricture of the duct, which in this case existed high up, was penetrated, and although the fluids and the probe passed readily, the epiphora continued because of the malposition of the turbinated bone. Indeed, this obstruction sometimes exists only in the form of a small flap of mucous membrane, which closes the entrance of the duct into the inferior meatus very much as a valve would do. This effectually prevents the drainage of the eye, and unless it is removed good results will not follow. In this particular instance it was very easy to see the obstruction by first passing a probe and then exposing the entrance of the duct into the meatus by means of a nasal speculum,—a slight

precaution which will often lead to the discovery of the cause of a persistent overflow of tears in spite of apparent permeability of the passages.

Case II. *Catarrhal dacryocystitis; bands of adhesion from the inferior turbinated body to the septum.*—Ella H., aged twenty-eight years, reported for treatment at the Philadelphia Polyclinic, October 24, 1891, on account of an inflammation of the right eye, which had existed for several days. There was a small abscess at the inner margin of the lower lid, with a fistulous communication into the lachrymal sac. A free muco-purulent secretion distended the sac in the form of an ordinary mucocele. The canaliculus had been slit at some previous time, but a probe did not pass readily.

She was referred to the throat department, and examined by Drs. Arthur Watson and Walter Freeman, who reported as follows: "Atrophy of both inferior turbinates; unable to obtain a posterior view; former ulceration of the posterior wall of the pharynx; bands of adhesion from the inferior turbinates to the septum; also one from the middle turbinate to the septum on the right side."

Even in the absence of definite history the pharyngeal condition seemed to indicate syphilis. The patient was ordered an astringent lotion, given potassium iodide and bichloride of mercury, and referred to the throat department for treatment. In January of this year an operation was made upon the lower turbinated bone, and the condition has improved without the passage of probes, the secretion and the epiphora having materially lessened.[1]

This case, it seems, illustrates the ordinary intra-nasal lesions which were evidently at the bottom of the lachrymal trouble, and is further interesting because these lesions gave confirmatory evidence of the syphilitic condition, so much so that relief was facilitated by the proper constitutional remedies.

Case III. *Lachrymal abscess; spur on the septum opposite the middle turbinated bone; chronic pharyngitis.*—Sarah S., aged forty-five years, reported for treatment at the Philadelphia Polyclinic, November 24, 1891. In April, 1891, epiphora began in the left eye, for which she seems to have undergone no treatment. It continued until about one week ago, when suppuration of the lachrymal sac took place. When she presented herself there was a very marked lachrymal abscess. The pus was evacuated by an external incision, the sac freely irrigated with an antiseptic fluid, and the patient referred to Drs. Watson and Freeman for an examination.

They reported as follows: "On the left side there is a spur on the septum opposite the middle turbinated bone; also hypertrophy of the

1. Recently there has been a relapse in this case. Attention to treatment has not been regular.

tissues. The turbinates are small. There is chronic pharyngitis, a thick phlegm covering the tissues."

Unfortunately, this patient has failed to report with any regularity, and the ultimate result cannot be given. This example illustrates the course of so many of these cases, namely, a chronic pharyngitis and hypertrophy and inflammation of the intra-nasal mucous membrane; involvement of the lachrymo-nasal duct; epiphora, owing to an obstruction primarily from swelling of the mucous membrane, and later from the formation of a positive stricture. Under the influence of the pressure and of the stricture, the fluids of the conjunctival sac are not drained, but distending the lachrymal sac, become infective, an abscess forms, and the condition which has been described results.

Case IV. *Epiphora : atrophic catarrh.*—Jane C., aged sixty years, reported for treatment at the Philadelphia Polyclinic, November 14, 1891, complaining of pain in her eyes, constant epiphora, and inability to read on this account. There was considerable hypermetropia and some astigmatism, and, as epiphora is frequently caused by the strain of uncorrected ametropia, proper glasses were ordered, but the overflow of tears continued. Both canaliculi were then slit. There was narrowing of the ducts, but no stricture, and probe and fluids passed readily. The epiphora improved, but did not disappear.

She was referred to the throat department, and the following report was received : "There is an atrophic condition on both sides, and a spur on the septum on the right side near the opening of the lachrymal duct, but it does not interfere. The closure is probably due to contraction from atrophic changes."

This is a good example of a very common condition, most frequent in elderly people, where there is neither disease of the sac, stricture of the duct, nor pressure from a spur of hypertrophy of the turbinated bodies, but where the obstruction depends upon contraction from atrophic changes.

Case V. *Phlegmonous dacryocystitis ; deflection of the septum ; spur on the left side pressing on the inferior turbinated bone.*—Matthew L., aged twenty-seven years, presented himself for treatment on account of an extensive lachrymal abscess with a small opening and widespread infiltration of the tissues, producing a large swelling involving the lower lid and cheek. The abscess was incised, the pus cavity freely washed out, and an antiseptic dressing applied. In a day or two the swelling had subsided, and nothing remained but a slight brawniness of the tissues and a fistulous opening at the point of incision. The canaliculus was slit, but all efforts to introduce the probe proved futile.

The patient had been much exposed to weather; had a history of an old injury, but denied syphilis. The obstruction to the tear passages had existed since the early Fall.

He was referred to the throat department, and the following report was received: "The septum is irregularly deviated in front; there is a spur on the left side pressing on the inferior turbinated body, which also contains an ulcer in its anterior portion."

He was warned that "catching cold," which would increase the nasal obstruction, would certainly bring about a relapse of the abscess. He went to work, however, and returned a few days afterward with all of the lesions previously described in a very much more aggravated state. The same treatment was instituted, and he was again referred to the throat department, and on the 23d of February the hypertrophy on the left side was removed. On the same day a probe was passed, and since this time its passage has been repeated. Epiphora still continues, but is decreasing day by day.

This example illustrates the mechanism of relapse in many of the tear-passage cases, in this instance producing a very serious phlegmonous inflammation. Under treatment and rest sufficient drainage takes place to produce amelioration of the symptoms; then swelling from congestion, owing to exposure, is added to the organic obstruction already present, producing complete closure with an exacerbation such as has been detailed.

Case VI. *Stricture of the nasal duct; moderate hypertrophy of the inferior turbinated on the left side and a spur on the right side.*—Bridget R., aged fifty years, applied for treatment to the throat department of the Philadelphia Polyclinic, and the following lesions were found: A moderate amount of hypertrophy of the left inferior turbinated near the nasal duct, and a spur on the septum of the right side close to but not obstructing the opening of the duct. With these lesions there were epiphora most marked in O. D., and slight lachrymal conjunctivitis. She had not been able for a number of months to use her eyes with any comfort. She was referred by Drs. Watson and Freeman to the eye department. The canaliculi were slit, and a stricture was found at the mouth of each sac. A No. 2 Bowman's probe was passed without difficulty.

It is evident that although there were lesions in the nasal passages, they were not obstructing the duct, but under the influence of the chronic nasal inflammation a stricture had formed in the lachrymal canal.

Case VII. *Epiphora from swelling of the mucous membrane of the lachrymo-nasal duct; atrophic rhinitis.*—A. K., an unmarried woman,

aged twenty-six years, was referred to me by Dr. Ralph W. Seiss, on account of epiphora of the right eye, which had persisted for some time in spite of the nasal treatment. There was no swelling of the lachrymal sac; no catarrhal or purulent secretion, but simply an overflow of tears. The general health was good, the eyes not far from emmetropic, and there was neither asthenopia nor headache.

Dr. Seiss has kindly furnished the following report of the nasal lesions: "Atrophic rhinitis presenting the ordinary appearances of tissue destruction, combined with some odor and much secondary laryngo-bronchitis."

The canaliculus was slit, and a No. 3 Bowman's probe was passed without meeting a stricture, but with a resistance to its passage, which is characteristic of obstruction from swelling of the mucous membrane. After the passage of this probe the duct was irrigated on several successive days with a solution of boracic acid and common salt, without, however, passing the canula into the duct. The fluid trickled readily through the nose. The epiphora stopped after a few treatments, and has never returned, although many months have gone by since she originally reported.

This patient represents a common class of cases of epiphora associated with chronic inflammation of the naso-pharynx. A somewhat similar inflammation occurs in the nasal duct, but does not produce a true stricture; the occlusion is from swelling, not from cicatricial changes. In many cases it is sufficient to do what was performed in this case; in others even milder measures suffice. Above all things, this is an example of a class of cases the successful treatment of which I have learned especially from Dr. Risley, by obeying the principle which he was wont to instil, not to be too ready to pass probes and canulas, lest their introduction scrape away some of the mucous membrane, and really do more harm than good. It is unnecessary to do more than medicate the swollen mucous membrane with any solution that is suitable; I like boracic acid and common salt very much.

Many more cases might be quoted, but these seven representatives of various classes are sufficient to illustrate the points which I desire to make:

1. A large class of cases exists characterized chiefly by epiphora without catarrhal or purulent secretion, in which the obstruction in the lachrymo-nasal duct depends upon swelling of its mucous membrane, and not upon true stricture. The primary origin of these cases in the great majority of instances is a chronic or subacute post-nasal catarrh. The evident indication is the

treatment of the latter condition and the medication of the swollen mucous membrane of the lachrymo-nasal duct, so that it may regain, as nearly as possible, its natural condition, which it will do without much instrumental interference,—an interference that may of itself, if unskilfully performed, be the cause of a cicatrizing band that never originally existed. Case VII. of the series illustrates this class.

2. The life history, if I may so express myself, of many cases of obstructive disease of the lachrymo-nasal duct and the formation of a lachrymal abscess is illustrated by Cases III. and VI. First, a chronic pharyngitis occurs; later, hypertrophy and inflammation of the intranasal mucous membrane, followed by swelling of the lining tissue of the lachrymal duct. Gradually cicatricial changes arise, and a true stricture is formed. The drainage of the conjunctival cul-de-sac ceases; the micrococci natural to the part, and those which readily find access to this region, permeate the contents of the lachrymal sac, because this can no longer be emptied; the pathogenic microörganisms exercise their true function, and suppuration occurs.

3. A number of cases develop, chiefly in old people, in which there is epiphora, again without the presence of pus or muco-pus, depending upon obstruction in the lachrymal duct from atrophic changes, the whole being part of a similar atrophic process in the intranasal passages, and generally described under the term atrophic catarrh. The obstruction in these instances is not from swelling, nor from stricture, but from contraction. Case IV. of the series is an example.

4. A very common cause of an exacerbation of lachrymal disease is due to the pressure of a hypertrophic turbinated body, or similar intranasal obstruction, which, under treatment, has gradually subsided, but which, owing to exposure, swells up again, and exercises its obstructing influence. At once there is occlusion of the lachrymal passages and recrudescence of the symptoms. The very serious nature of such cases is illustrated in Case V. of the series.

5. In every case of local disease the physician should be mindful of constitutional causes; the value of confirmatory evidence by pharyngeal and intranasal examination is illustrated in Case II., an example of constitutional syphilis. Local treatment may be very necessary; local treatment without general medication is ineffectual.

6. Finally, I come to the class of cases in which there exist an obstruction in the intranasal end of the duct (it may be trivial), permeable by the fluids used in a syringe, but an impassable barrier to the outflow of tears. Even the slightest obstructions, under these circumstances, may defeat the most classical treatment of lachrymal disease. The ready detection of such a lesion is illustrated in Case I. of the series.

It has not been my intention this evening to refer to what are the best means of treating lachrymal disease, except in so far as these are implied by the descriptions of the lesions which existed in the examples I have reported. Whether we believe that small or large probes should be passed ; whether we class ourselves with those who believe that the probes should not be used at all; whether we are the advocates of this or that antiseptic and astringent fluid ; whether we think that strictures should be incised or should not be incised, or whether we believe in the permanent wearing of styles or canulas, it is evident that the rational treatment of certain types of obstructive lachrymo-nasal disease must also include not alone the ordinary intranasal treatment with sprays and powders, but a systematic and thorough examination of the naso-pharynx, and, if necessary, the best operative interference known in intranasal surgery.

DISCUSSION.

Dr. Edward Jackson : I have very little to add to this paper. We are not in a position to generalize widely on this subject, or determine how many cases, or what proportion of cases, belong to that group in which the obstruction comes originally from the nasal chambers. Certainly I have not studied enough of these cases to go further than to simply consider individual instances and study the lessons that they seem to teach. A case that comes now to mind is one that was treated some years ago at the Polyclinic for lachrymal obstruction. He recovered, or at least got into such a good condition that he ceased to attend. Within a few months he returned to the clinic with a renewal of his epiphora, and on passing a probe I found no obstruction until the lower end of the duct was reached. There the obstruction was very noticeable, although no great difficulty was experienced in passing the probe. He was referred to the nose and throat department, and there was found a cicatrix involving the lower end of the duct. Whether this cicatrix was connected with the former treatment, or whether it resulted from the original nasal lesion, I am not prepared to say. Its excision certainly removed the obstruction to the flow of tears.

I recall two cases in which the thickening of the mucous membrane at the opening of the duct into the nose was the sole cause of the epiphora. Probably in the great majority of cases of lachrymal obstruction the original obstruction has been seated at one end of the canal. I do not think that it is always, and perhaps not in the majority of cases, that the trouble begins at the lower end of the canal coming from the nasal chambers. Frequently it commences with the puncta. Some of the obstinate cases that have come to me with a history of slitting up of the canaliculi, and long continued treatment with probes without permanent benefit, have shown a grave error in the position of the incision into the canaliculus. Instead of the conjunctival surface, the cut has been made on the upper edge of the lid, so that the tears could not get into the passage until they ran over the edge of the lid. These cases are liable to a return of the acute trouble, for if the normal flow of the fluid through the lachrymal sac and duct is not sustained, micrococci which enter find the conditions most favorable for free development and the setting up of pathological processes.

Dr. Samuel D. Risley: The facts which Dr. de Schweinitz has set forth in this admirably reported group of cases are of great practical importance, both to the ophthalmologist and those who treat the diseases of the nas-opharynx. The conditions so aptly described suggest many points of great importance. It recalls some of my early experiences in the treatment of lachrymal disease. I remember the case of a Mr. C., whom I had treated for a long time in 1879 for lachrymal retention unsuccessfully. There was no stricture of the duct other than that due to a more or less uniform thickening of the mucous membrane, but there was, nevertheless, more or less constant epiphora. Incidentally, he called my attention to some trouble with the nostril on the side of the affected tear duct. I discovered a broad superficial ulcer underlying the anterior end of the inferior turbinated bone. This was speedily cured by a few applications, and his lachrymal trouble soon disappeared. This was the first inkling I had received of the important relation which might exist between certain cases of lachrymal disease and affections of the nasal passages. At that time, so far as I knew, literature was silent upon the subject. From that time to this it has been my uniform practice to carefully inspect the nose in every case of lachrymal disease.

Dr. de Schweinitz's paper is an admirable statement of facts, with which my own experience is strictly in accord in a large group of cases suffering from this very troublesome and persistent affection. These facts explain why so many cases of epiphora present no marked stricture of the lachrymal duct. I have also had experiences the counterpart of that related by Dr. Jackson, where the probe was passed freely until the nasal end of the duct was reached, and there, meeting with

resistance, if forced roughly into the nose will cause bleeding from laceration of the inflamed and swollen mucous membrane, closing or blocking the nasal orifice of the canal.

Another practical bearing of these facts in ophthalmic surgery is, that since the lachrymal passages are liable to disease by extension upward from the nose, which furnishes such perfect conditions for the rapid development of microörganisms, the nasal passages may become the source of infection for the eye itself. It suggests the necessity for great care in this direction, particularly before and after operations upon the eye. We may deluge the conjunctival sac with antiseptic lotions before opening the anterior chamber, bandage the eye and imagine that all has been done for the safety of our patient, whereas the facts set forth this evening suggest the possibility of infection from the nose through the lachrymal duct. With this possibility in mind, I have of late years recognized the importance of washing out the lachrymal sac and nasal passages with bichloride of mercury solution where I expect to bandage the eyes after operation.

If affections of the nasal mucous membrane are then the origin of a considerable group of cases of lachrymal disease, it is obviously unwise to treat the duct harshly by probing until after the nasal disease is excluded. The function of the lachrymal duct is not performed in the manner of a drain-pipe, but is rather a capillary tube, and its inflammations may often be cured by washing with suitable lotions. Probing is often necessary, but rarely with the idea of dilating the capillary tube into an open canal. In 1877 I urged that the proper function of the probe was to induce absorption of the products of inflammation in the thickened membrane lining the duct, rather than the rupture of a stricture or dilatation of the duct.

Dr. Alexander B. Randall : I do not think I can add anything to what has been said. I have not met with a great deal of lachrymal trouble in the three or four thousand cases seen at the Episcopal Hospital. I have met, in that number, with only thirty that required absolutely lachrymal treatment. I recall a large number of cases where the nasal trouble seemed to be the cause of the affection, and where treatment directed solely to the nose has resulted most happily. In a large number of cases of children with watery eyes I have never, I believe, with one exception, used any other treatment than that to the nares and lower end of the duct, and have had no reason to regret the absence of other forms of treatment. I have always thought that the puncta, the arrangement of the canaliculi, and the arrangements of the upper part of the lachrymal passage, had a decided physiological purpose, and that it was a great disadvantage to treat these parts by incision and probing if there were no absolute necessity for it. In directing attention to the primary incision and to the constitutional treatment of the case, my results have been most satisfactory with

a minimum amount of necessity for surgical procedures directed to the upper part of the lachrymal passages.

Dr. Ralph W. Seiss: With regard to the nasal lesions found in these cases, in the instances that I have seen they have been almost altogether of two types. One is enlargement of the anterior nasal spine with ecchondroses of the septum and swelling of the mucous membrane; the other is atrophic and sclerotic changes. It is important to keep this in mind, as it has an important bearing upon the treatment. The galvano-cautery is an admirable agent in the treatment of nasal troubles, but it must be used with caution in these cases. I have seen seven or eight cases of lachrymal obstruction following the reckless use of this agent to the lower turbinated body. When I receive such a case for treatment I am more apt to use trichlor-acetic acid or a single crystal of chronic acid than the cautery.

Dr. L. Webster Fox: There was one point which was not discussed by Dr. de Schweinitz in his paper, and yet my observations have led me to believe that it plays a very important rôle in the causation of lachrymal disturbances, and that is, the asymmetry of the face A deviation from the middle line by the nasal bones or septum would perforce cause a modification of the calibre of the lachrymal canal on that side. Any irritating substance lodged in this constricted channel could not find easy escape, and in consequence inflammation develops which evidently would lead on to lachrymal abscess. Then, again, closure of both upper and lower openings of the canaliculi, caused by chronic conjunctivitis or blepharitis, proves again that asymmetry must play a factor in these cases, for with both eyes afflicted more or less, but one side of the drainage canal is affected. In 1884 all cases of lachrymal obstruction applying to the eye department of the Germantown Hospital were referred to Dr. S. MacSmith for nasal examination. I was in hopes that we could trace all lachrymal disorders to disturbances in the nasal cavities, but we were doomed to disappointment. While a certain number of cases had undoubted nasal complications, yet in many the lesion was found on the side opposite to the epiphora or lachrymal abscess. In some few cases we found the applied treatment to the nasal cavity did not give relief, but in the majority we found that you must apply treatment to the orbital end of the canal to obtain good results. Dr. de Schweinitz did not dwell upon the treatment of lachrymal disturbances, which I regret; for, after all, we desire to learn from each other the best means by which a cure may be brought about, or at least to alleviate our patients. My experience has led me to adopt the larger Cawper probes, followed by the insertion of a silver tube. In certain forms of epiphora a simple dilatation of the mouths of canaliculi will alleviate the patient, or slitting up, as suggested by Mr. Bowman; but where you have a stricture or lachrymal abscess, or

both, I adopt the radical treatment – dilatation to its fullest capacity. As regards the application of astringent washes, I have never had much success from their use alone.

Dr. Charles Hermon Thomas : The paper which Dr. de Schweinitz has read is an interesting and valuable contribution to the treatment of lachrymal obstruction. It, and especially the discussion which has taken place, has strongly emphasized a phase of the subject on which I confess I have not laid much stress in my own experience, which has withal been a not unsuccessful one. For a good many years I have had such satisfaction in the treatment of these cases as to leave little to be desired. I do not doubt that many of these cases can be relieved from the nasal side, but I must believe that there are a number of cases which can hardly be treated successfully in this way, exclusively cases in which the irritation has been so long continued that it has resulted in what might be called organic stricture as distinct as stricture of the urethra. Such cases certainly demand local treatment at the point of obstruction.

It was in 1868 that Stilling made the announcement of the results obtained by the use of the knife which he devised for the purpose of cutting strictures of the lachrymal duct. I was impressed with the value of the method of treatment proposed by him, and also with the want of adaptation of the knife which Stilling figured for the purpose. It seemed to me that the stiff, conical blade was faulty. I, therefore, devised a knife with a blunt conical tip, with the edge so set as to cut in withdrawing only, and attached to a flexible shank so that it could be bent to conform to the shape of the bony canal, and yet be rigid enough to control the blade. By slitting the lower canaliculus and first passing some of the more delicate probes, especially those of Dr. Williams, of Boston, this knife may be slipped down and a free lineal incision made. The stricture is then divided completely even to the bone, and a large leaden style is introduced and allowed to remain for a few days or weeks at most, being removed daily for a time, for the purpose of washing the passage with some antiseptic fluid. By this method I have had such success as seems to leave little to be desired, and can hardly think that the time has arrived to abandon that method altogether and turn these cases over to the rhinologist. Indeed, I do not now recall a single case in which I had difficulty from obstruction at the lower end after I had gotton a passage through. The facts brought out by Dr. de Schweinitz doubtless make it most desirable to have the nasal passages of patients suffering from epiphora examined, and any abnormalities found therein treated. It is my purpose to return to this subject in the near future, and to enter more into details as to the method of treatment here briefly sketched.

Dr. George M. Gould : I wish to go one step further than Dr.

Thomas in emphasizing the importance of ophthalmological treatment as such. There can be no question as regards cases such as Dr. de Schweinitz has presented. When there is absolute impermeability of the nasal end of the duct, the treatment is, of course, outlined by the diagnosis. In the greater number of cases, however, there is not absolute obstruction of the duct, but simply a stenosis, an unhealthy congested condition of the lachrymal mucous membrane, the duct certainly being patent to some extent, but not enough to carry off the large excess of tears. The frequent use of probes has seemed to me not only not necessary but simply superfluous in these cases.

During the past year I have employed a plan of treatment in such cases, which has been so successful that I shall outline it. It consists in slitting the punctum vertically downward toward the palpebral fold, in order to increase the size of the opening. Then canting the patient's head to one side, the corner of the eye is filled with an antiseptic astringent lotion. The duct should first be emptied by pressure, and then allowed to fill with this solution. This procedure of emptying and refilling the duct is repeated several times, and thus the antiseptic solution is brought in contact with canaliculus, sac, and duct by capillarity and pressure. I have had cases in which, after showing the patient the method once, he has afterward practised it himself and came back in a week perfectly cured. The method is simple and effective, and can be carried out at home. I have often wondered in those cases where probing has been employed, whether it was the probe or the antiseptic lotion that had done the good.

In regard to slitting of the canaliculus, I may say that I do not do this at the beginning of the treatment. If there is narrowing of the puncta, the fluid enters more readily if it is cut.

Dr. George Friebis: I should like to ask whether, in the experience of Dr. de Schweinitz, he has met with obstruction due to such causes as inflammation and enlargement of the caruncle? I have in mind one case (a male adult, past middle age,) in which I paid little attention to the inflamed caruncle, and the case did not improve under the routine treatment. Upon recognizing the inflammation of the caruncle as a possible cause, and treating it with astringents, I succeeded in curing the epiphora without further instrumental interference.

Dr. de Schweinitz: I have presented this series of cases simply for the purpose of classifying one of the many varieties of lachrymal obstruction. I beg Dr. Thomas will not think that I wish to transfer the treatment of lachrymal obstruction to my friends, the rhinologists, much as I value their aid in the management of some of these cases, and I heartily agree with Dr. Thomas and with Dr. Gould, that the ophthalmological treatment of lachrymal obstruction is of paramount importance. These cases illustrate merely certain failures in treat-

ment when applied to the ducts alone, because there is obstruction either at the inferior end of the duct or from intranasal lesion. I have not intended this evening to include the large number of cases due to obstruction in the canaliculus from polypi, from tear-stones, from fungus, or to the cases of obstruction high up, or to those which result from conjunctivitis and from malposition of punctum lachrymale. Dr. Fox's observation in regard to a symmetry of the face is an important one, and deserving of much study. In regard to the use of large probes, I might not find myself in accord with Dr. Fox. Abnormal position of the caruncle or its enlargement, as referred to by Dr. Friebis, is an interesting anomaly. You are all familiar with the cases reported by Von Graefe and by Horner. I have some knowledge of a similar case occurring in the practice of Dr. Wallace, of this city. Cases of this character, or others which have been brought up into discussion, have been purposely omitted in the paper of this evening. My idea was simply to show that certain examples exist, and they are not infrequent, which can be treated better with than without the aid of the rhinologist.

NEW YORK ACADEMY OF MEDICINE.—SECTION ON ORTHOPEDIC SURGERY.

Stated Meeting, March 18, 1892.

HENRY LING TAYLOR, M. D., Chairman.

ASYMMETRY OF THE EXTREMITIES.

Dr. L. W. HUBBARD presented two sisters exhibiting this condition. One child had one and a half inches shortening of the left lower extremity, and about two and a half inches shortening in the left upper extremity, which was about equally divided between the arm, forearm and hand. There was also slight shortening of the left ramus of the jaw. Her younger sister also exhibited about the same amount of shortening of the left upper and lower extremities. The muscles were developed in both cases. Their parents were healthy Germans, and there was no history of a similar deformity in other members of the family. An attempt had been made to explain this asymmetry on the theory that there is an unequal development of the cerebrum on the two sides.

Dr. A. B. JUDSON had seen a counterpart of these cases in a girl of eleven years, in whom the right ear and eye, as well as the right upper and lower limbs, were congenitally smaller than the left. He suggested wearing an ischiatic crutch on the larger side, and a high sole on the smaller side during the periods of

rapid growth. He thought that hip cases treated in this way owed the disparity in length of the limbs, which is found in the tibia, as well as in the femur, partly to the disease of one, and the over-use of the other. Advantage should be taken of this fact in the treatment of these cases of congenital asymmetry.

Dr. R. H. Sayre said that many writers had denied that want of symmetry in the lower extremities is a cause of true lateral curvature, and that the occasional association of the two conditions is a mere coincidence. Personally, however, he believed that if the children first presented were allowed to go on to puberty without the employment of measures to equalize the limbs, they would certainly develop true lateral curvature. In one of the cases the lack of development did not seem to him to be entirely confined to one-half of the body, as the left side of the face appeared larger than the right, although the extremities were smaller on the left side than on the right. On this account, he did not think the theory that this asymmetry was due to unequal development of the two halves of the cerebrum, could be correct.

He agreed with the previous speaker that much of the atrophy following hip disease was due to lack of use, and he therefore heartily endorsed his suggestions as to treatment.

Dr. A. M. Phelps said that his experience had led him to believe that the shortening of the limb in hip disease is never due to anything but bone destruction, and that the employment of the treatment suggested would effect no change in the length of the limbs, although it might increase their circumference.

Dr. R. H. Sayre said that after cases of club-foot have improved sufficiently to enable them to use their feet, it is noticed that there is not only an increase in the bulk of the feet, but also in the length of the bones. It had also been observed in colleges where careful records are kept of the physical condition of the students, that those who exercise regularly in the gymnasium not only have larger muscles, but are taller than those who do not avail themselves of this opportunity for physical training.

RESULTS IN CASES OF HIP DISEASE TREATED BY THE PORTABLE TRACTION SPLINT WITHOUT COMPLETE IMMOBILIZATION EXCEPT DURING THE INFLAMMATORY STAGE; WITH ILLUSTRATIVE CASES AND PHOTOGRAPHS OF CASES.

Dr. Lewis A. Sayre read a paper with the above title. He held that absolute immobilization of the diseased joint during the

entire period of treatment, as advocated by a number of writers in the past few years, was not always essential to complete recovery, and he presented detailed histories of seven cases in support of this view. The diagnosis in all these cases had been confirmed by other surgeons of recognized ability, who had seen them in consultation. Photographs of five of these patients were exhibited, which showed absolutely normal mobility of the joint, the photographs being taken with both legs straight, and the patient in the standing position, and also with the foot of the diseased side on top of a chair, and again, with the patient sitting with the foot of the diseased side on the knee of the opposite side, and the knee of the diseased side dropped so as to make the leg parallel with the floor. One patient was present who could do all motions equally well with either hip, and another, who was shown as a *good* but not as a perfect cure, who could put either foot on top a chair in front of him, and who could cross his legs, but who was unable to put the foot on the diseased side in his lap, as could all the other patients whose histories were reported in full.

Dr. Sayre then gave the following statistics of 407 cases of morbus coxarius, which he had treated between the years 1859 and 1889, exclusive of exsections :

First stage, 118 ; second stage, 119 ; third stage, 82 ; not mentioned, 88. Total number of cases, 407.

RESULTS.

Cured, motion perfect, 71 ; cured, motion good, 142 ; cured, motion limited, 83 ; cured, anchylosed, 5 ; unknown, 78 ; under treatment, 14 ; abandoned, 3; discharged, 2. Died of exhaustion, 2 ; died of phthisis, 1; died of pneumonia, 1; died of tubercular meningitis, 5. Total deaths, 9. Total number of cases, 407.

Cases in which the author knew the result, and also the kind of splint worn between 1859 and 1889, excluding cases under treatment. Cures with perfect motion, long splint, 19 or 21.59 per cent.; short splint 54 or 28.12 per cent. Cures with good motion, long splint, 34 or 38.63 per cent.; short splint, 86 or 44.79 per cent. Cures with limited motion, long splint, 29 or 32.95 per cent.; short splint, 49 or 25.52 per cent. Cures with anchylosis, long splint, 3 or 3.40 per cent.; short splint, 1 or 0.52 per cent. Deaths, long splint, 3 or 1.56 per cent.; short splint, 2 or 1.04 per cent. Treated with long splint, 88. Treated with short splint, 192. Total, 280.

The plan of treatment pursued in these cases had been rest in

bed, usually with a blister behind the trochanter when the case was seen in the early stages, combined with traction in the line of the deformity with such weight as gave the greatest relief, while the body and sound limb were secured to a long splint passing from the axilla to the foot. In certain cases, lateral traction was also added. This was first used by Dr. Sayre in 1868. When the acuteness of the joint spasm had subsided, and the deformity had been overcome, the line of traction having been gradually changed until the limbs were parallel, the child was allowed to get up with the short splint and crutches in some cases, and in other cases with the long splint, either with or without crutches, according to circumstances. The author did not enter into the details of application, as these had previously been fully described. Cases involving both joints had been treated in the wire cuirass, as far as possible, in order to allow of driving in the sun and air. The limbs were occasionally removed from the cuirass, one at a time, for the purpose of making slight motion of the joint, inside the degree of causing pain. Traction was considered as one of the requisites of treatment, as the author had seen cases go on to extensive suppuration with entire destruction of the acetabulum, from reflex pressure, in spite of constant fixation by plaster of Paris for two years without traction. He had also seen a case of anchylosis of all the joints of the trunk and lower extremities in a case that was kept constantly in a cuirass for nine months without motion. The anchylosis in this case was not accompanied by any fever or pain, so that the supposition that a rheumatic diathesis was responsible for this condition, was untenable.

Cases of exsection had not been included in the table of statistics, as they had been published separately, and most of them had been in such advanced stages when first seen as to preclude the possibility of mechanical treatment.

DISCUSSION.

Dr. Judson agreed with the writer of the paper that traction does not secure complete immobilization, but rather fixation, or a fractional and sufficient degree of immobilization. Fixation thus produced, relieves pain and hastens recovery, but does not prevent the correction of deformity, which is brought about conveniently and surely as soon as the patient, wearing the hip splint or the ischiatic crutch, is taught to observe habitually the natural rhythm of walking. Adduction and flexion are thus reduced, because the

limb reaches outward and downward in abduction ; and extension, in order to do its share of the work of progression which is thrown upon it by the footsteps, is equalized. He had been pleased to find that not only is deformity reduced, but also the range of motion is increased in the joint when the limb is summoned in this way to do, as far as it can, its half of the work of locomotion.

Dr. Phelps said that while listening to the paper, he had been impressed with the striking difference between the statistics presented by the author and those published a few years ago by Shaffer and Lovett, notwithstanding that all these gentlemen used the same plan of treatment. In thirty-nine cases reported by the last two gentlemen named, nineteen had anchylosis, and seven were in a condition almost equivalent to anchylosis. The author of the paper which had just been presented, deserved to be congratulated on the large number of magnificent cures which he had obtained. The speaker admitted that he had become somewhat prejudiced against the long traction splint, partly as a result of experience, and partly because of the publication of the statistics which he had just quoted. Where anchylosis had occurred, he believed it was due to trauma which had been produced by allowing the patient to walk upon the apparatus, or on account of a joint in the splint which allowed free motion, or because traction had not been made in the axis of the neck. He considered that the introduction of the long traction splint marked a distinct advance in orthopedic surgery, but he thought still further advance would follow attention to the points just mentioned, and it was on this account that he had adopted the plan of complete immobilization. The long traction splint was born of a fear of anchylosis, and a desire that the patient should have exercise ; yet, in his own experience, which embraced a large number of dispensary cases of the worst class, anchylosis had not occurred in a single one of the cases which he had treated during the past four years. The members would, doubtless, recall the cases that he had previously presented, which, although completely immobilized for periods of about one year, still had complete motion of the joint. He did not believe that fixation of a joint, either diseased or healthy, resulted in anchylosis. The fact that anchylosis was not a constant result of fixation, proved this theory to be erroneous. The "ossified man," during the early stages of his disease, had been subjected to all sorts of manipulations, yet every joint became anchylosed. He believed the case of anchylosis reported in the paper was due to some affection of the nervous

system, and was not the result of the immobilization. Anchylosis is determined by the character of the inflammation, its severity and duration, the parts involved, and the subsequent cicatricial contraction of the capsule of the joint, and he could not see how passive motion could prevent such destructive changes. The long traction splint, no matter how applied, will allow the foot to be elevated 35°, by tilting of the band at the pelvis. He preferred this instrument, however, to the short traction splint. Although he had employed lateral traction at first without knowing that it had been used before, he had since found several references to it in literature, showing that it had been used many years ago by Busch.

While on the subject of the use of the long traction splint, he wished to call to mind the fact that cases of hip-joint disease present great differences, and that some which run a favorable course are accompanied by much pain, while others which are associated with extensive destruction of bone have very little pain. He hoped that everyone using the long traction splint would have as fortunate an experience as had the author, but for the present he felt that he must continue to use his lateral traction splint.

Dr. John Ridlon said that, in a paper which he had written a few years ago on the subject of Fixation and Traction, he stated that as he had never met with a patient who had worn the short splint, he thought this splint could not be used much in this vicinity. He wished to take this opportunity to say that, since writing that paper, he had seen three cases which had previously worn this splint. He had been especially interested in Dr. Sayre's statement that he had secured better results with this instrument than with the long traction splint. Some years ago, he had come to the conclusion that the long traction splint was positively harmful as a walking apparatus, as it seemed to increase "the pumping action" at the joint. That it should do so, seemed reasonable when one recalled the fact that, with a traction of from five to ten pounds, and a splint weighing from six to eight pounds, the patient at each step stands upon the splint, lifting the well leg and relaxing all traction. The effect of this upon the joint can be easily imagined, when it is remembered that a child running about takes two or three thousand steps an hour. That this splint does exert a harmful influence in this way, seems to be still further confirmed by the better results which the author had obtained from the short traction splint. As many of the cases had been treated at different times by both the long and the short splints, it was difficult

to say how much of the good result was to be attributed to the one or the other splint. It seemed to him that some cases of hip joint disease seemed to recover, no matter what the method of treatment adopted, or even when they were entirely untreated. We had not yet found out what was the essential vital principle in the treatment of each individual case. As an instance of this, he cited the case of a child whom he had treated most carefully for six years, and yet the result was not as good as in the case of a sister of this child who had gone through the entire period of hip disease without any surgical treatment. It was true that some of his cases which should be on crutches were walking around on the limb, because he was unable to control them, yet he was free to admit that it did not seem to have hurt them.

Dr. Halsted Myers said that the majority of cases of tubercular osteitis of the hip have the primary local focus in the neck of the femur at the junction of the epiphysis and shaft. We can recognize this condition by appropriate tests, and as at this stage there is no involvement of the cartilages of the joint, it is obviously unnecessary to immobilize the joint; yet it is *most important* that concussion and pressure should be taken from the inflamed and softened bone, and that there should be no possibility of the weight of the body being thrown on that limb. He believed that in a number of cases the disease never extends beyond this location, and is cured *in situ*. He had no pathological specimens to prove this point, nor has it been investigated as yet; he spoke from a clinical standpoint. In cases where there is erosion of the joint surfaces bearing against each other, he thought motion is injurious, as well as pressure, and is plainly indicated by the presence of reflex muscular spasm, which is a reliable guide. We always find reflex muscular spasm at the point where motion is injurious. On the other hand, immobilization of a disorganized joint, *provided pressure is also relieved*, he had never seen to cause any permanent injury to the joint. To show the importance of the relief of pressure in this connection, he stated that in order to relieve pain, he had had to apply traction to a case of hip disease which was wearing a Thomas splint, correctly shaped and applied. Recognizing the importance of this evidence, he had made repeated careful observations, but always with the same result, that traction was in this case necessary for the relief of pain.

Dr. H. W. Berg wished to protest against the feeling of nihilism which might be engendered by Dr. Ridlon's remarks. If we were

able to make a purely pathological diagnosis instead of a generic one—"hip disease"—we might be able to point out in advance those cases which would do well and those which would do ill.

Dr. W. R. Townsend said that while not wishing to detract in the least from the credit due the author for securing such excellent results, he desired to point out the fact that one factor contributing to this end, was undoubtedly the very favorable surroundings of his patients. Again, the author could hardly have selected better cases had he desired to illustrate the traumatic origin of hip disease; and the fact of many of the cases reported having such an origin, affords still further reason for the excellence of his results. Bone tuberculosis and an osteitis due to traumatism may give the same clinical symptoms, but they should give different ultimate results.

Dr. Judson said that for a number of years he had kept a description of all the hip splints he had applied, and their weight had ranged from one to one-half pounds in the case of a child to little over five pounds for a large adult.

He thought that some of us were dissatisfied with the hip splint because we expect more than the nature of these cases allows. We cannot cut short hip disease as we can break up chills with quinine. We must put the part and the system in the most favorable position attainable, and then wait for the processes of natural repair. This is best done by making traction, so long as it is needed, and protecting the limb throughout the treatment from the traumatism of walking, while locomotion is freely practised. Traction and protection are the features of the American method, by which it is distinguished from the Liverpool method of portable leverage, and the London method of recumbent traction. The results obtained by Dr. Sayre are good, but not exceptional. They are within the reach of all who adhere to the plan of treatment which has been outlined.

Dr. R. H. Sayre said that the fact that one man regards a case as tubercular, and another as non-tubercular, did not change the character of the lesion, nor influence the progress of the disease.

Regarding the question of the occurrence of anchylosis, he said that he believed some cases would become anchylosed whether motion was allowed, or entirely prevented, and as an illustration of this he recalled a case of double hip joint disease in which the disease on one side was very severe, and was accompanied by extensive suppuration, while on the other side it ran a much milder course. During the progress of the disease in the latter joint, she

was kept in bed or in a wire cuirass, yet notwithstanding this treatment and the apparently mild course of the disease, absolute anchylosis was the result, while in the other joint good motion was secured. Again, after the disease was apparently arrested in both joints, and both seemed to be equally stiff, passive motion gave a good joint on the side which had suppurated, but resulted in no benefit to the other side. He had seen a number of cases of disease of both hips and knees, in which the joints seemed to be perfectly fixed until passive motion was instituted. He did not approve of leaving these stiffened joints to be loosened up by the ordinary motions which the patient would make.

Dr. Phelps said he agreed with the other speakers as to the value of forcible breaking up of adhesions under ether, but he could not understand how motion of a joint during inflammation could *prevent* anchylosis. As the inflammatory material which limits the motion during inflammation is absorbed, there will be an increased motion of the joint, and, in his opinion, active motion on the part of the patient was better than passive motion. He had frequently produced by passive motion a return of the pain and stiffness in the joint.

Dr. Townsend could not see how anyone could believe that an osteitis due to traumatism represented the same pathological process as one due to tuberculosis, although the clinical symptoms might be identical.

The Chairman said that while all must admit that the statistics presented in the paper are not only brilliant, but exceedingly valuable, in comparing them with the statistics of those who do not resort to excision of joints, allowance must be made for those joints which had gone on to excision. This would also affect the mortality. One point which was very strongly brought out in the paper, was the positive, decided, and immediate relief of pain obtained in the majority of cases from traction properly applied. In hip joint disease, it is fair to infer, as is also evident from the results obtained, that if the pain is relieved, the treament is beneficial to the joint. He believed in immobilization in the acute stage, so far as it could be produced by traction, but he did not believe it was necessary to go up to the axilla and immobilize the spinal column. Sometimes traction must be supplemented by recumbency, and sometimes by the use of crutches; these were all the necessary elements for the proper management of those cases which can be successfully treated by mechanical means. His own

experience had led him to think that by far the most efficient method of applying traction was by means of the long traction splint.

Dr. Sayre, in closing the discussion, said that the statistics presented were only those which had been fully completed, and they represented forty years of work. He thought Dr. Phelps had misunderstood him about the question of motion at the joint. He had always advocated, repeatedly and persistently, rest of an inflamed joint, but he *permitted* such motion as the patient would himself make. He did not consider that any motion which would not cause pain was injurious. He applied sufficient traction to prevent pressure on the joint, and it was all important that this traction should be made in the proper direction. He did not approve of an unyielding strap, which, in the splint used by Dr. Taylor and Dr. Shaffer, is attached to the pelvic band and the shaft of the splint; in his opinion, it should be made of elastic webbing.

As regards the etiology of his cases, he did not pretend to say whether or not the processes were tubercular or non-tubercular. At the time he began his investigations, everything was called "scrofula," and medical men believed that tubercle was always found in the lungs before it was deposited in other parts of the body. Having learned from autopsies on some cases of hip-joint disease that there were no tubercles in the lungs, he began to doubt the tubercular nature of this disease, and he was led to look upon it as a chronic inflammation resulting from a greater or less degree of traumatism. Now that the presence of tubercle bacilli furnished a definite basis for a diagnosis, he was trying to learn something about the occurrence of tubercle in these cases. Clinical experience had taught him, however, that whether these cases were tubercular or not, fresh air, good food, and freedom from pain were the essentials for a cure.

Referring to the occurrence of anchylosis, he said that one single case of absolute, firm anchylosis of all the joints in the body was worth more to him than any number of experiments on dogs. In the case which he had reported in his paper there was no fever, no evidence of any nervous derangement, in fact, there was no constitutional disturbance. To apply a splint without traction is wrong; nothing makes better immobilization than plaster of Paris, and it is much more comfortable than the Thomas brace, yet it is insufficient, without traction, to overcome the reflex muscular contraction, and to relieve pain. The treatment which he advocated

was the best possible one, no matter what the etiology of the disease.

Dr. JOHN RIDLON exhibited a convenient pocket-knife, with blades especially designed to facilitate the removal of plaster of Paris bandages.

Progress in Medical Science.

MEDICAL JURISPRUDENCE.

CONDUCTED BY

HENRY A. RILEY, A. B., LL. B., New York.

LIFE INSURANCE AND DEATH CERTIFICATES.

PHYSICIANS, in the course of their professional duty, are necessarily required to furnish certificates of the causes of death for various purposes. This is required of them by the health laws in most cities, and the certificates are of great value in making up the vital statistics, upon which much of our sanitary and health legislation is based. For failure to file such a certificate in the proper office is generally a misdemeanor, and punishable by fine and imprisonment, or both.

It is often the case also that, in claims under life insurance policies, one of the most important "proofs of death" is the certificate of the attending physician, giving the cause of death, with other information.

Does the physician violate any law of professional ethics in giving such a certificate, and does he break the statute law, which, in most States, provides that the physician is not allowed to disclose any information obtained by him in a professional capacity, and which is necessary for the proper treatment of the patient? These are important and interesting questions.

In the case of the reports to the health boards, there can be no question that the physician is obliged to make such reports, and that no rule of professional etiquette is violated by doing so.

In the other case of certificates to insurance companies, a somewhat different question is involved. Both of these points were raised, however, in a recent New York case, and the decision will be of interest.

The cause of death, in this instance, was delirium tremens,

and an admission of it would prevent a recovery on the part of an infant beneficiary who could not protect himself.

The attending physician made a report, both to the insurance company and the Board of Health, and gave the cause of death as delirium tremens. Did he wrong the beneficiary by so doing? On the trial, the company offered both certificates in evidence as conclusive evidence against the plaintiff. The Court held, however, that they could not be admitted so as to bind the infant. In the case of the Board of Health report, it was held that public records of this description were not competent evidence in actions between private parties where the cause of death was the main question in issue. It must be proved in other ways.

In regard to the report to the insurance company, the Court held that it would have been a conclusive admission against the plaintiff if he were an adult, but that the rights of an infant ward could not be lost by the admission of his guardian, and the certificate was, on this ground, refused as evidence.

The policy of insurance did not require the cause of death to be stated, but only called for satisfactory proof of death, and this could be furnished without disclosing the cause. The act of the physician in furnishing the certificate was not considered as reprehensible, because he was asked to give it by the guardian of the infant, and it was supposed to be necessary to secure payment, although, in fact, it was the most efficient means of preventing a recovery.

It would be well for physicians to remember that, in cases of suicide, etc., a statement of the cause of death may be prejudicial and may also be entirely unnecessary.

THE PROPER TREATMENT OF CRIMINALS.

An article in the New York *Independent*, not long since, gave a careful *résumé* of the Penal Code of Italy, which went into operation January 1, 1890. The writer states that the only sound basis of penal punishment is protection of public order and private rights. He repudiates, as unphilosophical and untrue, the theory that the infliction of punishment is because the offender has done wrong. This elimination of the moral element in crime is rather startling, and the writer says that his theory has not been put in practice by the Italian Code, and laments that the best opportunity of "making a memorable epoch in the progress of scientific legislation" has been lost.

The following paragraph will be of interest, as stating clearly the writer's position :

But, in nearly all cases, there is better use for a man than to bury him in prison. It is this conviction that has dictated the Penal Code of New Zealand, under which none but immediately dangerous convicts are imprisoned, all others being placed under the guardianship and tutelage of such reputable citizens as will undertake the charge.

This system has built up a public spirit in the community, such that men of wealth, especially of large estates in land, vie with one another in assuming the care of youthful offenders, and rescuing them from a criminal career.

It has been, in part, copied in Massachusetts, where the system of probation officers and parole, practised so successfully of late years for juvenile offenders, is now extended to all who are convicted for the first time of less serious crimes.

There is reason to hope that it will profoundly modify the penal codes of all civilized nations, since the limited experience of it hitherto indicates that it is the surest and most efficient means ever devised of preventing the formation and growth of a criminal class.

A NEW YORK MALPRACTICE CASE.

A MALPRACTICE suit has just been tried against a physician of Fishkill Landing, New York, with the result of awarding a verdict of $2,500 damages against him. Some time since a drayman fell from his cart and broke his arm. The bone protruded from the flesh, and the wound was filled with dirt. It was dressed and looked after by the physician, but the patient found it necessary to enter St. Luke's Hospital, New York, after about a month, at which time the arm was swollen to double its usual size. When he left the hospital, the arm was useless and will always remain so. Suit was therefore brought for malpractice, the claim being made that the wound was not properly cleansed. The damages were laid at $5,000 and a verdict given for $2,500.

MUSIC AND CHURCH BELLS IN COURT.

THE ringing of church bells has often proved to be a nuisance, by reason of the long continuance or untimeliness of the clanging, and the aid of the law has been invoked frequently to prohibit it. This has been the case in England and also in several of the states of our own country. In a case reported not long since in the newspapers, a curious question, not of bells but of music, arose. The

chorister of a church was discharged for some reason, and took his revenge by sitting in the congregation and singing purposely out of tune. The congregation apparently did not know what to do, and an application for an injunction was thought of, but, we believe, not tried. An arrest for disturbing public worship would probably have met the exigencies of the occasion. This last case occurred in North Carolina, which seems to be particularly affected by musical troubles.

In one instance, occurring not long since, a female prisoner was solacing the tedium of her enforced retirement by singing, although the wife of the jailor was sick, and he requested her to stop. When she refused to do so, the jailor severely beat her with a horsewhip. This was considered a harsher form of criticism than the rendering of the music demanded, and upon a trial the jailor was sentenced to pay a fine of $100. In another case, also in North Carolina, not music but public worship was involved, as it seems that the defendant engaged in a prize fight near a church during service. Some one happened to announce the fact in church, whereupon the congregation ran out. The accused, rather curiously, was acquitted of the charge of disturbing public worship.

MEDICO-LEGAL AND MEDICO-ETHICAL.

DENHOLM VS. TAIT.

This case came before Mr. Justice Collins at the Manchester assizes last week. Mr. Gully, Q. C., M. P., Mr. Bingham, Q. C., and Mr. Sutton were for the plaintiff: Mr. Kennedy, Q. C., and Mr. Ashton for the defendant. Mr. Gully said that the plaintiff in this action was Dr. Denholm, a physician and surgeon practising in Manchester for many years past. The defendant, Mr. Lawson Tait, was an eminent surgeon practising at Birmingham. He was a specialist and an operator. The action was one for libel.

The statement of the counsel and the evidence of the plaintiff showed that the plaintiff had been suffering for some years from uterine myoma, which, in 1889, began to cause inconvenience. Dr. Lloyd Roberts and Mr. Whitehead were consulted by Dr. Denholm, under whose care the patient had been for some years, and recommended the use of Apostoli's electrical treatment. That treatment was continued for some time, but without effect, and in the course of the treatment an accident occurred in the operation, which gave

rise to a vesical fistula. This fistula was twice operated upon, but each time ineffectually. In December, 1891, the patient, Mrs. Payne, consulted Mr. Tait, who, it was alleged, blamed the electrical proceeding, and advised removal of the tumor. According to the statement of Mr. Gully, Q. C., he advised an operation, and said the risk was very small indeed,—that he only lost one case in sixty. Mrs. Payne asked Mr. Tait particularly about the fistula, and he said that he could put the matter right. Mr. Tait told Mrs. Payne's husband that the risk attending the operation might be put at five per cent. at the outside. The lady underwent the operation, and Mr. Gully suggested, for reasons which he stated, that the lady was not at the time in proper condition of health to be operated upon. Soon after the operation the husband called, and was told the patient was going on splendidly, but within forty-eight hours he got a telegram summoning him at once to his wife, who was much worse. Half an hour after he arrived she died, without having recognized him. The husband was anxious to see Mr. Tait, but was unable to do so. The following letter, which contained the alleged libel, was handed to him:

MY DEAR SIR. — I saw your wife, with Mr. Christopher Martin, between two and three this morning, and matters were going on very fairly with her. At 7.30 I was summoned again, and found her sinking. You were summoned at once, and, I am glad to learn, reached her bedside before she died. The immediate cause of the unfortunate result is the rupture of a blood-vessel at or near the spot where the electrical needles caused so much damaging inflammation and sloughing. Had she never been submitted to that treatment, the case would have been a straightforward one, and her recovery almost certain.

Whether privileged or not, which they would have to consider, that meant that death was owing to the fact that her previous medical attendant had submitted her to the electrical treatment. Mr. Payne naturally considered this letter as imputing that the death of his wife was entirely owing to improper medical treatment before the operation, and when he got back to Manchester he immediately went to see Dr. Denholm, to whom he showed the letter. The plaintiff took the letter as containing a charge against himself, and told Mr. Payne the charge was entirely unfounded and untrue, that hemorrhage was not the cause of death, and that the best way to find out the cause of death was a *post mortem* examination, which was afterwards carried out by three eminent medical men, the result of which was to show that death

was not due to hemorrhage, or a rupture of a blood-vessel, or to damaging inflammation and sloughing consequent upon the previous electrical treatment. What it did show was that death had resulted from peritonitis, the result of the operation. Mr. Gully then detailed the condition of the patient after the operation, and gave her temperature, pulse, and treatment up to her death.

Witnesses were called to show, as the result of *post mortem* examination, that the cause of death was not hemorrhage as suggested, but peritonitis. It appeared, however, that the *post mortem* examination had been made by gaslight in the coffin, and that the hematocele of the broad ligament had been overlooked, while the evidence of peritonitis was very slight.

Mr. Kennedy, in his statement for the defense, pointed out that it was admitted by Mr. Gully that Mr. Tait was entitled and bound to make a truthful report to the husband of the lady as to what he considered to be the facts of the case and the causes of unsuccess. The letter, if honestly written, as lawyers knew, was written on a privileged occasion. It was a letter on the part of Mr. Tait which legally, morally, and socially he was entitled to write. The writer wrote the facts, as he believed, of the case, but the other side alleged that that statement was erroneous in fact, and that it reflected upon the treatment which the patient had received from others. It was admitted that so long as Mr. Tait wrote what he honestly believed to be the facts, his letter was privileged. If it were otherwise, life would be intolerable. It would be impossible that life could be tolerated if the truth might not be stated, however unpleasant to others, on privileged occasions. Where, however, a person said a thing, not because he believed it, but to do someone an injury, then the law properly stepped in and made the party responsible, and the privilege no longer existed. In this case the whole evidence of the other side had been directed to show that the statement in the letter written by Mr. Tait was not merely erroneous as regarded the cause of death, but that it was a statement which Mr. Tait could not have honestly believed to be the truth. That his client denied. Mr. Kennedy then detailed the circumstances of the case, and proceeded to call evidence.

Mr. Lawson Tait was then called. He gave the notes of his conversation and of the examination of the patient. The myoma was a large one, and a tumor which had grown in seven years to that size would reach a fatal size before change of life. There was

a history of dysmenorrhea, and the failure of the electrolysis; the production of the fistula, in the cure of which two distinguished surgeons, Mr. Whitehead and Dr. Lloyd Roberts, had failed, was absolutely unique in his experience. He was perfectly certain that the fistula could not be cured until the tumor was removed. If he had said anything at all about percentages, he could only have said, in the communication to Mr. Payne, that the failures were from eight to ten per cent. There was a history of inflammatory symptoms after electrical operation. In the operation, the tumor was found to be very adherent to the peritoneum, as the result of inflammation, and the operation took over an hour. He maintained his opinion as expressed in the letter, and he had nothing to withdraw.

Mr. Gully, on behalf of the plaintiff, and without calling the witnesses of Mr. Tait, said that having heard the statement of the defendant, his client in the fullest manner withdrew the imputation that Mr. Tait had wilfully or recklessly misstated the cause of death; and Mr. Walter Whitehead, who had stated in the box that in his opinion Mr. Tait had recklessly operated on the patient, now having heard Mr. Tait, wished to withdraw that statement.

Mr. Kennedy said that he concurred with that view, and accepted the full and handsome withdrawal of any imputations against Mr. Tait's character, and he (Mr. Kennedy) could only repeat what he had said in the beginning, and what Mr. Tait had said in his letter, that he had no intention whatever of reflecting upon the character of the medical gentleman who had attended Mrs. Payne.

The Judge said he was exceedingly pleased at the close of the case. He could not help feeling that if the parties had had the opportunity of meeting and knowing the facts of the case on both sides, these difficulties would never have arisen between them.

Mr. Tait said he fully accepted Mr. Walter Whitehead's withdrawal.

It is reported that the combined obstetrical experience of Barker, Taylor, and Thomas, of New York, Penrose and Wallace, of Philadelphia, and Chatard, of Baltimore, covers a period of two and a quarter centuries, during which they have attended at the births of over forty-five thousand children, and they have been compelled to perform the operation of craniotomy less than twenty times.—*Toledo Medical Compend.*

BUFFALO MEDICAL AND SURGICAL JOURNAL

A MONTHLY REVIEW OF MEDICINE AND SURGERY.

EDITORS:

THOMAS LOTHROP, M. D. - - WM. WARREN POTTER, M. D

All communications, whether of a literary or business character, should be addressed to the managing editor. 281 FRANKLIN STREET, BUFFALO, N. Y.

VOL. XXXI. MAY, 1892. No. 10.

A NATIONAL MEDICAL BENEVOLENT FUND.

DR. FREDERICK HORNER, in an interesting paper published in the *Journal of the American Medical Association*, April 16, 1892, advocates the creation of an American Medical Benevolent Fund, the object of which shall be to afford immediate pecuniary relief to distressed qualified members of the medical profession, or their widows and orphans in case of death of a member. Dr. Horner cites the example of the British Medical Benevolent Fund, which shows that it is doing a most admirable work in the way of relieving those members who come within the range of its benevolence. There are also several States that have established physicians' aid associations, and these are referred to in Dr. Horner's paper. A number of cities or counties have also organized similar institutions, all of which are doing their work in the most satisfactory manner. We are of the opinion that it is wise for physicians to seek mutual protection of the kind that is indicated in Dr. Horner's admirable article, and hope that his paper will lead to an agitation of the subject, and a consequent establishment of the system.

The New York Mutual Aid Association, which is referred to in the paper, is doing a most gratifying work, and it seems to us there is no reasonable excuse why its membership should not be very much increased. In the State of Kentucky such an association numbers over 2,000 members, and it would seem as though New York should easily have an association of 4,000 or 5,000 physicians. Let Buffalo do her share, at any rate, and then we shall not feel ashamed of our attitude toward this good cause. There is no good or logical argument why physicians should not protect themselves, in the manner indicated, while there are many in its favor.

CURRENT TOPICS.

The State of Kentucky, always loyal to legitimate medicine, has a most novel and satisfactory way of dealing with traveling or itinerant doctors who pretend to practise within its boundaries. We learn from the Cincinnati *Lancet-Clinic* that the City of Bowling Green, Ky., has passed an ordinance setting forth that it shall be unlawful for any traveling or itinerant doctor to practise medicine in any of its branches within the limits of the State. The penalty for the violation of the ordinance is from $50 to $100 for each day of such violation. Similar ordinances have been passed in Lexington, Paducah, Harrisburg, Lebanon, Stanford, Franklin, Glasgow, Elizabethtown, and several other cities, and is reported to be pending, with the probability of passing in nearly every other city and town in the State of Kentucky. We commend the idea to other states that are afflicted with these parasites.

The Ohio Medical Practice Act, that has been pending in the State Legislaturese, ems to have been strangled by a combination of quacks and irregulars, who have overwhelmed the better element in Ohio. We are not surprised at this defeat, because we have had a similar experience in our own State. It took us many years to convince the Legislature that it would be wise for the State to assume the right to grant license to physicians independent of medical colleges, and in the struggle we met not only the opposition of the quacks, itinerant pill peddlers, and other human vermin, but we are sorry to say that some of the most orthodox, the most ethical (?), and the most solid members of the profession in the State were detected in secretly conniving to prevent the passage of such a measure. Year after year, however, we crossed swords with them in the halls of the capitol, in committee rooms, in medical societies, and in the clubs, until we finally overwhelmed them, and have succeeded in obtaining a very complete and efficient law. More 's the pity, however, that we have been thwarted in carrying out its provisions for a year or two, by the combinaton of medical students who have succeeded in obtaining exemptions from this statute. The medical profession, from one end of the State to the other, has joined hands with New York, Brooklyn, and Buffalo, in endeavoring to check the pernicious legislation referred to, with what effect at this writing we know not, but we hope for the best. Meanwhile, we feel sure that the classes of '93 in this State will be subjected to the operations of the law.

The Food Manufacturers' Association has introduced a novelty with reference to its proposed exposition, to be held in Madison Square Garden, in October next. We refer to the engagement of the Seidl Orchestra, which, under the direction of Herr Anton Seidl, is to conduct afternoon and evening concerts during the entire time of the exposition. This will afford the public an opportunity to hear most delightful music, and thus will be combined the esthetics and the substantials of life in a most novel and acceptable manner.

Dr. C. H. Mastin, of Mobile, President of the American Surgical Association, in his address delivered in Washington in September, 1892, paid an eloquent tribute to the late Dr. Samuel David Gross, and recommended that the association should take upon itself to initiate a movement for the erection of a suitable monument to perpetuate the memory of this most distinguished American surgeon.

The American Surgical Association does not propose to monopolize the honor of this grand project, but it appeals to the entire American profession to come forward with contributions and with good will to enable it to carry out its design. Committees and sub-committees have been appointed, and Dr. John B. Roberts, 1627 Walnut street, Philadelphia, has been chosen treasurer; all contributions, therefore, should be sent to him.

We need not do more than to call the attention of the profession to this subject, for we feel sure that it is one that will appeal to its sense of propriety without further urging on our part. The amount needed to erect an imposing statue in bronze, of heroic size, upon a granite pedestal, the whole being about sixteen feet in height, will not exceed $12,000. The committee now only requires a little more than $8,000, and it would seem to us that this amount should be promptly subscribed.

The first decennial catalogue of the College of Physicians and Surgeons, of Chicago, has lately come to our table. It is by far the handsomest college announcement and catalogue that we have seen, and might be adopted as a model by other American colleges with great propriety. The fine photographic reproductions of the college building and Cook County Hospital, that appear as frontispieces, introduce the book, which consists of eighty-two duodecimo

pages carefully indexed, in a most favorable way; but particularly do we note that the requirements for admission to this college are of the most satisfactory character. These requirements are plainly and distinctly named in unmistakable terms, and it affords us much pleasure to say that among the equivalents of the preliminary education which this college expects is the certificate of the Regents of the University of the State of New York. The course of study is definitely planned, and covers four years, each year to consist of a Winter term of twenty-six weeks, with the usual Spring term addendum of twelve weeks, which latter is optional.

Among the requirements for graduation we note the following: "(3.) Four full years of study of medicine under the direction of a physician or medical college recognized by the Illinois State Board of Health as such." Surely the degree of the College of Physicians and Surgeons of Chicago may be well worth contending for, and when obtained it will be considered throughout the land as evidence of ample equipment by the young physician.

The Toronto General Hospital has lately issued its annual report for the year ending September 30, 1891. It is a handsome brochure of 107 pages, illustrated with lithographs and woodcuts of the hospital buildings as they formerly appeared, and as they now look with the improvements recently made upon them. Besides the ordinary record of cases treated and their several classifications, there are divisions of the report relating to medical education, history of the hospital, description of the hospital buildings, and a roster of the trustees from 1853 to the present. The ambulance service is given in detail with illustrations, and, finally, the annual report of the training school for nurses is added. Taken all together, this is one of the most complete and useful hospital reports that we have seen, and reflects much credit upon all concerned in that useful institution, but especially upon the medical superintendent, Dr. Chas. O'Reilley, who has held the position for more than sixteen years.

It seems to us that this is the proper way to govern a hospital, in order that its patients may receive the full benefit of the most skilful attention. A medical superintendent who is fitted for the work will be obeyed and respected when others will not, and thus insure perfect subordination in all the various departments.

The *American Journal of Obstetrics* for April contains the following official announcement:

The Section on Gynecology and Abdominal Surgery at the Pan-American Medical Congress has been organized by the election of Dr. William Warren Potter, 284 Franklin street, Buffalo, N. Y., as Executive Chairman; Dr. Brooks H. Wells, 71 West 45th street, New York City, as English-speaking Secretary; and Dr. Ernest W. Cushing, 168 Newberry street, Boston, as Spanish-speaking Secretary. The Foreign Secretaries of the Section so far selected are: *The Argentine*, Dr. Dn. L. C. Maglioni Llobet, Victoria 737, Buenos Ayres; *Brazil*, Dr. Dn. Luiz da Cunha Feiho, Rio de Janeiro; *British North America*, Dr. Jas. F. W. Ross, 481 Sherborne street, Toronto, Canada; *Columbia*, Dr. Dn. José W. Buendia, Calle 10, No. 212, Bogota; *Nicaragua*, Dr. Juan I. Urtecho, Calle Real, Ciudad Granada; *Spanish West Indies*, Dr. Dn. Gabriel Casuso, Virtudes 37, Habana, Cuba; *Uruguay*, Dr. Dn. Enrique Peréy, Uruguay 371, Montevideo.

Last month we called attention to the fact that Dr. E. E. Montgomery had resigned the Obstetrical Chair in the Medico-Chirurgical College for the purpose of devoting himself exclusively to teaching in the gynecological department of that college. We have in another place alluded to the fact that Dr. Montgomery has since been appointed Clinical Professor of Gynecology in Jefferson Medical College, and hence severs his connection with the Medico-Chirurgical institution. The Board of Trustees of Jefferson Medical College have also established the following clinical professorships, electing Dr. F. X. Dercum, Professor of Nervous Diseases; Dr. E. E. Graham, Professor of Children's Diseases; Dr. H. Augustus Wilson, Professor of Orthopedic Surgery; Dr. H. W. Stelwagon, Professor of Dermatology, and Dr. W. M. L. Coplin, Adjunct Professor of Hygiene.

Messrs. Charles Truax, Greene & Co. propose to establish a bureau of service and information to be operated by them during the entire session of the World's Fair free of all expense to the medical profession. They offer their services in regard to obtaining hotels, and boarding houses, the receipt and delivery of telegrams, postal facilities, banking conveniences, together with many other attentions that relate to the entertainment of visitors during the Columbian Exposition. The services connected with this bureau are entirely free to the medical visitors in attendance at

the fair, and is another indication of the many generosities of the Chicago inhabitants. It will, no doubt, be a great convenience to the profession, and will be largely visited during the season.

The *International Medical Magazine*, edited by Dr. Judson Daland, and published by J. B. Lippincott Co., Philadelphia, is a handsome large octavo of over 100 pages, which number first made its appearance in February of the present year. Among its other many interesting features, it has established a medico-legal department, in which it will deal with the legal responsibilities incident to the practice of medicine and surgery, that will prove of interest and value to the general practitioner and specialist. Taken all in all, this is one of the handsomest printed and most systematically arranged of all the general medical magazines that we have seen, and we feel assured that it will command a large patronage almost at once.

A special examination in medicine will be held at 21 Cooper Union, New York City, May 3-6, 1892, to accommodate candidates for license to practise in this State. The examination will be conducted in accordance with the usual daily programme, and will be held in New York City only. Candidates who desire admission to this examination must file application blanks not later than Saturday, April 30th. The next regular examination will be held June 14–17, 1892.

Papoid, or Vegetable Pepsin, is now becoming recognized as a medicine of value, and will, undoubtedly, take its place in the official list very soon. It is manufactured by the Papoid Company, Johnson & Johnson, Sole Agents, 92 William St., New York, who have recently issued a most interesting pamphlet containing information as to the methods of administering papoid, and many other facts that have been gleaned from American and foreign literature and grouped in a single brochure, very convenient for reference.

The Graduating Exercises of the Medical Department, Niagara University, will take place Monday evening, May 2d, at the Star theatre. Exercises begin at 8 o'clock P. M. The commencement exercises of Buffalo University will take place on same date and hour, at Music Hall.

Personal.

Dr. E. E. Montgomery, Professor of Gynecology in the Medico-Chirurgical College of Philadelphia, has been elected Professor of Clinical Gynecology in Jefferson Medical College. This is another evidence that Jefferson is making a fight for the supremacy, and she appears destined to resume her old place as a strong and well-equipped medical school. Dr. Montgomery has demonstrated the fact that he is one of the best teachers of clinical gynecology in the country, and Jefferson is to be congratulated in securing him for that chair.

Dr. J. L. Eddy, of Olean, one of the most prominent physicians of the southern tier, has been appointed aide-de-camp on the staff of the State Commander of the Grand Army of the Republic. This is a fitting recognition of Dr. Eddy's military service, and of his devotion to the interests of soldiers.

Dr. A. A. Hubbell, Professor of Ophthalmology in Niagara University, sailed for Europe in the early days of April. He will enjoy a two months' vacation, visiting the important clinics of Europe, and return about June 1st, in season to participate in the Summer society meetings.

Wm. C. Krauss, M. D., of Buffalo, has been appointed associate editor on the staff of *Neurologisches Centralblatt*, published by Prof. E. Mendel, of Berlin, Germany.

Dr. F. J. Thornbury, formerly resident physician at the Cincinnati Hospital, has permanently located in Buffalo, and established his office at 610 Main street. Dr. Thornbury has lately spent some months in Europe engaged in bacteriological studies, and is well equipped for the practice of his profession.

Errata.—Page 586: *has* instead of had, tenth line from the bottom. Page 587: *achromatopsia* instead of actromatopsia, tenth line from the bottom. Page 588: *regurgitant* instead of engurgitant, eighteenth line from the bottom.

The selection on page 619, Medico-Legal and Medico-Ethical, Denholm vs. Tait, is from the *British Medical Journal*, April 2, 1892.

Book Reviews.

TREATISE ON GYNECOLOGY, MEDICAL AND SURGICAL. By S. POZZI, M. D., Professeur Agrégé de la Faculté de Medecine; Chirurgien de l'Hôpital Lourcine-Pascal, Paris; Honorary Fellow of the American Gynecological Society. Translated from the French edition under the supervision of, and with additions by Brooks H. Wells, M. D., Lecturer on Gynecology at the New York Polyclinic; Fellow of the New York Obstetrical Society, and the New York Academy of Medicine. Volume I. With 305 illustrations and six full-page plates in color. Large 8vo, pp. xxiv.—581. New York: William Wood & Company. 1891.

The literature of gynecology has been enriched within the last ten years by the contributions of many able men, but there is no book that has been issued from the press, either in this country or in Europe, that has impressed us with the degree of perfection, and the conscientious work of the author, that this book of Pozzi must ever be associated with in the minds of his readers. It is based upon Pozzi's large practical experience as a hospital surgeon and teacher, and is, consequently, teeming all through its pages with the elements of originality, which lends a charm to any author's work.

Chapter I., on Antisepsis in Gynecology, brings to our notice, at the very outset, the consideration of a most important question —one of the most important connected with the whole practice of this art. Wherever else antisepsis may be needed, or may not be requisite, certainly here it is of the first importance, and a knowledge of its application is essential to the successful practice of gynecology; hence, this subject very properly forms the opening chapter in the book. How different from the treatises of fifteen or twenty years ago, that began with long and dry chapters on the anatomy of the pelvis, and the organs it contained, which really had little or no place in works on gynecology, because the treatises on anatomy were requisite to supply knowledge in this direction. Following antisepsis comes Anesthesia in Gynecology, which occupies Chapter II., and these two chapters are of the greatest interest. We wish that every physician might read them, whether he be a gynecologist, a surgeon, or a general practitioner.

Pozzi's methods of suture and hemostasis are both interesting and instructive. Though his methods of examination contain nothing beyond the ordinary, his chapter on the Pathology and Etiology of Metritis is excellent. He deals with the question of

uterine fibromata in a masterly manner, and his chapters on this subject are full of new thought. In regard to cancer, besides the

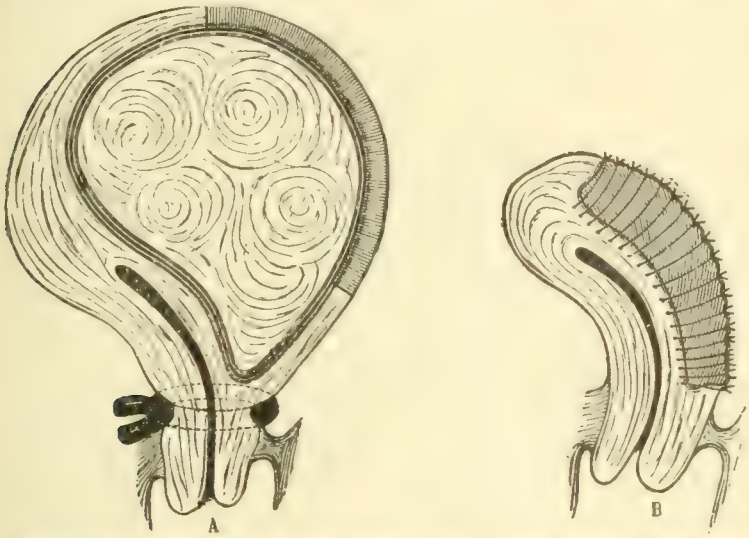


Fig. 151.—*A*. Enucleation of an interstitial myoma. *B*. Disposition of sutures after enucleation.

usual operations heretofore recommended in text-books, vaginal hysterectomy has a large place, and Kraske's sacral resection is fully described. The usual space is given to the treatment of dis-

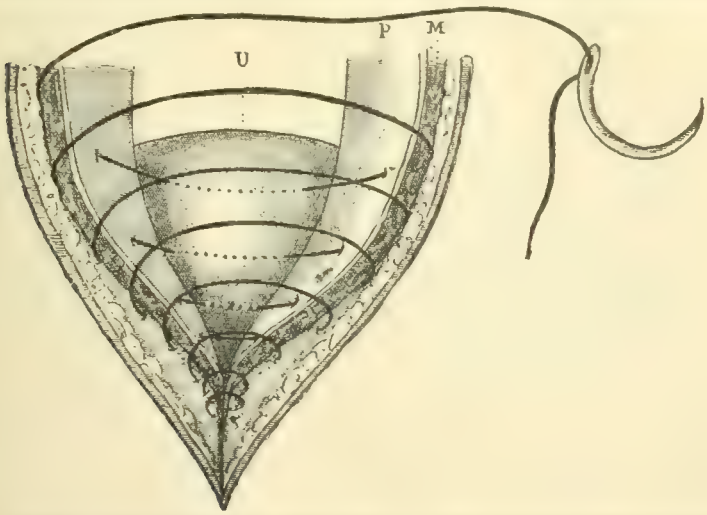


Fig. 255.—Gastro-hysteropexy. Pozzi's method. Fixation of the anterior face of the uterus with a hemstitch of silk.

placements of the uterus, and a great many pessaries and their methods of application are described in detail. The new operations of vaginal hysteropexy and gastro-hysteropexy are fully and amply described and illustrated. Plastic operations of the genital tract are also fully and elaborately dealt with, and the book closes with the subject of Disorders of Menstruation. At the end of each chapter is a voluminous bibliographical reference list, and some of the illustrations are especially to be commended for the clearness with which they bring out the author's meaning. This is especially the case with reference to the methods of suturing, and also the operations upon tumors, the treatment of the pedicle, and all work connected with pelvic and abdominal operations. Some of the old cuts that have done duty with reference to prolapsus of the genital organs might have been omitted without being missed, but, in the main, the book is admirably illustrated, as the two figures which we introduce will indicate. It is printed upon heavy book paper, in large octavo form, containing 581 pages, exclusive of the preliminary matter, and is one of the handsomest books, in its press-work and general make-up, that we have seen for many a year. The translator, Dr. Brooks H. Wells, has contributed not a little to make the book interesting to American readers. The translation is as smooth as though it had been written originally in English, and some of the chapters are marvelously well constructed in their phraseology and tersely put sentences.

We commend this book to the specialist and the general practitioner as well. If the latter should obtain it and read it, he will wonder that he could ever have known so little of the subject of which it treats.

A Manual of Venereal Diseases: Being an Epitome of the Most Approved Treatment. By Everett M. Culver, A. M., M. D., Pathologist and Assistant Surgeon Manhattan Hospital of New York City; Member of the American Association of Andrology and Syphilology, and late of the Department of Venereal Diseases of the Vanderbilt Clinic; and James R. Hayden, M. D., Chief of Clinic Venereal Department of Vanderbilt Clinic, College of Physicians and Surgeons, New York. With illustrations. Philadelphia: Lea Brothers & Co. 1891.

This book is a practical treatise, presenting in a condensed form the essential features of our present knowledge of the three venereal diseases, syphilis, chancroid, and gonorrhea. For a long period of time, even up to within a very recent date, the ravages of syphilis were considered to be of much more importance and

much more destructive to the human race than those of gonorrhea; but since the studies of Neisser, and the promulgation of the doctrines of Noeggerath, gonorrhea and syphilis have changed places with reference to their importance, prevention, and dangers. An uncured gonorrhea is capable of inflicting more permanent mischief upon the innocent members of society than almost any other disease that can be named.

It is a great question whether there should not be some established rule by which innocent women can be prevented from marrying with men who are already contaminated, and will surely infect a previously healthy and innocent wife. This is a matter of so much importance that every practitioner, especially in the smaller cities and towns, and even in the rural districts, should familiarize himself with the methods of diagnosis, prevention and treatment of the three maladies that are so ably handled by the authors of this book. We have examined this work carefully, and have come to the conclusion that it is the most concise, direct, and able treatise that has appeared on the subject of venereal diseases for the general practitioner to adopt as a guide. The specialist, of course, must possess himself of exhaustive treatises, and familiarize himself with the technique and minutia of his craft, but the general practitioner needs a few simple, concise, and clearly presented laws, in the execution of which he cannot fail to either cure or prevent the ravages of the maladies in question and the direful results which their propagation entails.

A MANUAL OF HYPODERMATIC MEDICATION: The Treatment of Diseases by the Hypodermic or Subcutaneous Method. By ROBERTS BARTHOLOW, A. M., M. D., LL. D., Emeritus Professor of Materia Medica, General Therapeutics and Hygiene in the Jefferson College of Philadelphia; Honorary Fellow of the Royal Society of Edinburgh; Honorary Member of the Société Medico-Practique de Paris; Fellow of the College of Physicians of Philadelphia; Member of the American Philosophical Society; Fellow of the Medico-Chirurgical Faculty of Maryland; Honorary Member of the various State and local Societies; Author of a Treatise on the Practice of Medicine; of a Treatise on Materia Medica and Therapeutics; of a Manual of Medical Electricity, etc., etc. Fifth edition, revised and enlarged. Philadelphia: J. B. Lippincott Company. London: 0 Henrietta street, Covent Garden. 1891.

It seems like meeting an old friend who has been absent for some time and come again to visit us, to once more find this valuable book on Hypodermatic Medication, by Bartholow, on our library table. The first book that we ever saw on this subject was written

by this author, and he has continued to be recognized as almost alone in this field of authorship. When his first edition was published, its range was limited to a few drugs only, and the work was necessarily much smaller than the present treatise. Now we have a formidable array of drugs that can be administered hypodermatically, and their physiological effects are oftentimes so different and so much enhanced by this method over the ordinary stomachal administration, that we must needs have a separate and distinct law laid down to guide us in this field.

The present treatise, although professing to be the fifth edition of a former issue, is essentially a new book. Most of the articles have been either recast or rewritten, and so much new matter has been introduced that it is no longer the same book. It is something like the boy's jack-knife with new blades, new handle, new back, and new rivets, but has all been done by the same master, who thoroughly understands the old as well as the new, and has maintained the usefulness of the instrument by carefully forging and tempering its new parts. Every practitioner of medicine, no matter what his specialty, should possess Bartholow's manual, for it will not only serve as a guide to him in doubtful conditions, but will instruct him in many hitherto unknown ways. We are pleased to see that the author has retained the word hypodermatic, which he introduced in the fourth edition, in place of the old familiar term hypodermic, which was employed in the earlier issues. This book is a handsomely printed small octavo of 540 pages, including an excellent index, and is easily worth the price which the publishers mark it at.

Transactions of the Association of American Physicians. Sixth session, held at Washington, D. C., September 22, 23, 24, and 25, 1891. Volume VI. Philadelphia: Printed for the Association. 1891.

The sixth volume of the Transactions of this Association of Eminent Medical Practitioners is similar in style and size to the preceding numbers. The sixth session was held in Washington in connection with and as a part of the second Congress of American Physicians and Surgeons. This volume contains twenty-three titles, most of which have been already published in abstract in the medical journals. They are in the main such as are of interest to practitioners of internal medicine, but there are a few titles that can be read with interest by gynecologists and abdominal surgeons.

Among the latter we may mention a discussion on the Remote Results of the Removal of the Ovaries and Tubes, by Wm. T. Lusk, M. D., Wharton Sinkler, M. D., and James J. Putnam, M. D. We are somewhat surprised in reading this discussion by men who are not only able physicians but profound scholars, to find such an expression as the following: "A recent writer, himself a laparatomist, says, etc." (page 87). Now, if there is any excuse at all for the word laparatomy, which is a misnomer in nine times out of ten when applied to abdominal surgery, we insist that the word laparatomist, as applied to abdominal surgeons, is about the worst mongrel in derivation and meaning that could possibly be constructed. We wish the terms "laparatomy" and "laparatomist" were stricken out of the vocabulary of medicine.

Nerve-Stretching in Inveterate Trigeminal Neuralgia, by James Stewart, M. D., will interest both physicians and general surgeons, while the paper on Intestinal Perforation in Typhoid Fever by Reginald H. Fitch, M. D., is another of the author's important clinical contributions to the study of intestinal surgery. The volume is handsomely printed, and edited by the recorder, Dr. I. Minis Hayes, in a most finished and excellent manner. We are always glad to add the volumes of the Transactions of this Association to our library.

A Practical Manual of Diseases of the Skin. By George H. Rohe, M. D., Professor of Materia Medica, Therapeutics, and Hygiene, and formerly Professor of Dermatology in the College of Physicians and Surgeons, Baltimore, etc., etc. Assisted by J. Williams Lord, A. B., M. D., Lecturer on Dermatology and Bandaging in the College of Physicians and Surgeons; Assistant Physician to the Skin Department in the Dispensary of Johns Hopkins Hospital. No. 13 in the *Physicians' and Students' Ready-Reference Series*. In one neat 12mo volume, 303 pages. Extra cloth. Price, $1.25 net. Philadelphia: The F. A. Davis Co., Publishers, 1231 Filbert street.

There is no more difficult class of diseases to understand or to control, in so far as the general practitioner is concerned, than those which involve the skin when they are of a chronic nature. The dermatologist masters the science of the specialty with considerable ease and much perfection, but the general practitioner continually prays to be delivered from the treatment of chronic skin diseases. Dr. Rohé has had a large experience both as a specialist and as a general practitioner, and writes from a standpoint that makes his book of great value to the professional world. In

the preparation of the book, the distinguished author has also had the valuable assistance of Dr. Lord, his clinical aid at the College of Physicians and Surgeons in Baltimore, and between the two they have contrived the most valuable little manual that we are familiar with. We advise every physician who lives at a distance from the great centers to obtain this book and read it carefully. It will give him much additional light on what has oftentimes proven a dark subject to him, and enable him to conduct his cases with much more satisfaction to himself and his patients. He will cure many of the milder diseases, will early recognize the intractable forms, and will speedily send them to a dermatologist who will aid him in his dilemma.

DISEASE OF THE BLADDER AND PROSTATE. By HAL. C. WYMAN, M. Sc., M. D., Professor of Surgery in the Michigan College of Medicine and Surgery, Detroit; Member of the American Medical Association, Michigan State Medical Society, Michigan Surgical and Pathological Society, Detroit Academy of Medicine; Surgeon Detroit Emergency Hospital, etc., etc. The Physician's Leisure Library. George S. Davis, Detroit, Mich. 1891. Price, cloth, 50 cents; paper, 25 cents.

The importance of a complete understanding of the pathological management of diseases of the bladder has only lately come to be appreciated by the great mass of physicians. It has only recently been shown that an uncured gonorrhea leaves in its wake a multitude of diseases and disturbances that entail a life of suffering, or else shorten what might otherwise be a long and pleasant existence. Any contribution leading to a better understanding of these diseases is welcomed by physicians who properly appreciate their importance. The little volume before us is a condensation of the principal points that are presented in the management of the several diseases of the bladder and prostate. We commend it to the careful study of the profession.

A PRACTICAL RESUME OF MODERN METHODS EMPLOYED IN THE TREATMENT OF CHRONIC ARTICULAR OSTEITIS OF THE HIP. By CHARLES F. STILLMAN, M. Sc., M. D., Chicago. The Physician's Leisure Library. Detroit: George S. Davis. 1891. Price, cloth, 50 cents; paper, 25 cents.

There is no more important office that a physician can fulfil than to relieve a little sufferer from hip disease, and put such a child on his feet cured and ready to deal with the realities of life. We always feel a tenderness for, and an appreciation of, everything

that the orthopedic surgeon does; hence, have nothing but praise for his work, which is so often one of charity, and generally without compensation commensurate to the service performed. The book before us is a careful *résumé* of the progress that has been made in this department of surgery, and we commend it to the favor of the general practitioner, who may from it get an inspiration that will lead him to send his cases promptly to a competent orthopedic surgeon, and not wait until the favorable time has passed to arrest the disease without deformity or with only slight lameness.

THE CHINESE, THEIR PRESENT AND FUTURE: MEDICAL, POLITICAL, AND SOCIAL. By ROBERT COLTMAN, Jr., M. D., Surgeon-in-Charge of the Presbyterian Hospital, at Teng Chow Fu; Consulting Physician of the American Southern Baptist Mission Society; Examiner in Surgery and Diseases of the Eye for the Shantung Medical Class; Consulting Physician to the English Baptist Mission, etc. Illustrated with fifteen fine photo-engravings. Philadelphia and London: F. A. Davis, publisher. 1891.

This book does not seem to be one that especially falls within the province of the medical practitioner or that belongs to the literature of medicine; but it is, nevertheless, an interesting portrayal of the methods and habits of the life of this strange race that inhabits the eastern world. In this book will be found a careful setting forth of the home-life of these singular people, and many anecdotes are told of them in an interesting and agreeable manner. The opium habit is touched upon, and much new light thrown upon this method of dissipation. The most interesting chapter to medical men is that upon leprosy, which deserves to be read by students of this horrible malady. An insight is given into the missionary life of the Celestial Empire, and a chapter is devoted to business opportunities, while in another the political situation of the Chinese is discussed. The book closes with a short chapter on future prospects of China, and it is handsomely illustrated with photo-gravures. Taken altogether, it is a most interesting and readable book.

THE YEAR-BOOK OF TREATMENT FOR 1892. A Critical Review for Practitioners of Medicine and Surgery. Philadelphia: Lea Brothers & Company. 1892.

Again are we called upon to notice this valuable little annual, and we cannot do the profession better service than to say that year by year it appears with improved and still more valuable

material. The practitioner who leads an active life, especially in the country, cannot always put his hand upon every journal or volume that issues from the press, and, consequently, some condensed book, grouping together the salient features of treatment that have been brought out during the year, becomes a necessity. The one before us easily supplies the want named, and we recommend it to all who need to consult such a work.

Sleep, Insomnia and Hypnotics. By E. P. Hurd, M. D., Member of the Massachusetts Medical Society; Member of the Climatological Society; Member of the Société de Medicine Pratique (Paris, France); one of the Physicians in the Anna Jaques Hospital, Newburyport, Mass. The Physician's Leisure Library. George S. Davis, Detroit, Mich. 1891. Price, cloth, 50 cents; paper, 25 cents.

To successfully treat insomnia is frequently one of the most perplexing duties of the physician. He must master all the idiosyncrasies of his patient, not only in so far as they pertain to his morbid condition, but also with reference to the effect upon his economy that the various drugs have. He must control the methods and habits of life of the insomnolent victim, and he must in many ways assume a knowledge of human nature in its multifarious aspects and deviations from the normal line. In this book will be found many valuable hints that will lead to a solution of the difficult problem of inducing sleep when it will not come unaided, and we think that the author has handled the matter with wisdom and discretion. It is a readable little volume, and deals with the subject in a masterly manner. A not unfrequent classical quotation adds much to the pleasure of its reading.

BOOKS RECEIVED.

Transactions of the American Surgical Association. Volume the IX. Edited by J. Ewing Mears, M. D., Recorder of the Association. Philadelphia: Printed for the Association, and for sale by William J. Dornan. 1891.

The Principles and Practice of Medicine. Designed for the Use of Practitioners and Students of Medicine. By William Osler, M. D., Fellow of the Royal College of Physicians, London, Professor of Medicine in the Johns Hopkins University, and Physician-in-Chief of the Johns Hopkins Hospital, Baltimore. Formerly Professor of the Institutes of Medicine, McGill University, Montreal; and Professor of Clinic Medicine in the University of Pennsylvania, Philadelphia. New York: D. Appleton & Co. 1892.

The Pocket Pharmacy with Therapeutic Index. A Résumé of the Clinical Applications of Remedies Adapted to the Pocket-Case, for the

Treatment of Emergencies and Acute Diseases. By John Aulde, M. D., Member of the American Medical Association, of the Medical Society of the State of Pennsylvania, of the Philadelphia County Medical Society, etc. New York: D. Appleton & Co. 1892.

Fourth Annual Meeting of the National Association of the Railway Surgeons. Held at Buffalo, N. Y., April 30 and May 1, 1891. With a Historical Sketch of the Association, List of Members, and other Matters Relating to the Association. Illustrated, with portraits of the officers of the association and others. Published by the *Railway Age and Northwestern Railroader*, Chicago, Ill.

The Mediterranean Shores of America; or, The Climatic, Physical, and Meteorological Conditions of Southern California. By P. C. Remondino, M. D., Member of the American Medical Association, of the American Public Health Association, of the State Board of Health of California; Vice-President of the California State Medical Society, and of the Southern California Medical Society. Illustrated with forty-five engravings and two double-page maps. In one handsome, royal octavo volume, 176 pages. Extra cloth, price, $1.25 net; cheaper edition, bound in paper, price, 75 cents net. Philadelphia: The F. A. Davis Co., publishers, 1231 Filbert St.

A Manual of Diseases of the Nervous System. By W. R. Gowers, M. D., F. R. C. P., F. R. S., Consulting Physician to University College Hospital; Physician to the National Hospital for the Paralyzed and Epileptic. Second edition, revised and enlarged. Volume I., Diseases of the Nerves and Spinal Cord. With 180 illustrations, including 370 figures. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut street. 1892.

The Book of Prescriptions, containing upwards of 3,000 Prescriptions, collected from the practice of the most eminent physicians and surgeons, English and foreign, comprising also a compendious History of the Materia Medica, List of the Doses of all official or established preparations, and an index of Diseases and Remedies, by Henry Beasley. Seventh edition. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut street. 1890.

Fifth Annual Report of the State Board of Health and Vital Statistics of the Commonwealth of Pennsylvania. Transmitted to the Governor, December 2, 1889. Harrisburgh: Edwin K. Myers, State Printer. 1891.

Sixth Annual Report of the State Board of Health and Vital Statistics of the Commonwealth of Pennsylvania. Transmitted to the Governor, December 1, 1890. Harrisburgh: Edwin K. Myers, State Printer. 1892.

Practical and Analytical Chemistry. A Complete Course in Chemical Analysis. By Henry Trimble, Ph. M., Professor of Analytical Chemistry in the Philadelphia College of Pharmacy. Fourth edition. With illustrations. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut street. 1892.

International Clinics: A Quarterly of Clinical Lectures on Medicine, Surgery, Gynecology, Pediatrics, Neurology, Dermatology, Laryngology, Ophthalmology, and Otology. By Professors and Lecturers in the leading medical colleges of the United States and Great Britain and Canada. Edited by John M. Keating, M. D., Philadelphia, Consulting Physician for Diseases of Women to St. Agnes' Hospital, Philadelphia; Editor

Cyclopedia of the Diseases of Children. J. P. Crozer Griffith, M. D., Philadelphia, Clinical Professor of Diseases of Children in the University of Pennsylvania; Professor of Clinical Medicine in the Philadelphia Polyclinic. J. Mitchell Bruce, M. D., F. R. C. P., London, England, Physician and Lecturer on Therapeutics at the Charing Cross Hospital. David W. Finlay, M. D., F. R. C. P., London, England, Physician to the Middlesex Hospital, and to the Royal Hospital for Diseases of Chest; Lecturer on Clinical Medicine in the Middlesex Hospital Medical School. October, 1891. Philadelphia: J. B. Lippincott Co.

Evidences of the Communicability of Consumption. By G. A. Heron, M. D. (Glas.), Fellow of the Royal College of Physicians, of London; Physician to the City of London Hospital for Diseases of the Chest. London: Longmans, Green & Co., and New York, 15 E. Sixteenth street. 1890.

Bacteriological Diagnosis: Tabular Aids for Use in Practical Work. By James Eisenberg, Ph. D., M. D., Vienna. Translated and augmented with the permission of the author from the second German edition, by Norval H. Pierce, M. D., Surgeon to the Out-Door Department of the Michael Reese Hospital; Assistant to Surgical Clinic, College of Physicians and Surgeons, Chicago, Ill. Philadelphia and London: The F. A. Davis Co., Publishers. 1892.

Diseases of the Urinary Apparatus; Phlegmasic Affections. By John W. S. Gouley, M. D., Surgeon to Bellevue Hospital. New York: D. Appleton & Co. 1892.

A Text-Book of Nursing for the use of training schools, families, and private students. Compiled by Clara S. Weeks-Shaw. Second edition, revised and enlarged with illustrations. New York: D. Appleton & Co. 1892.

Drinking Water and Ice Supplies and their Relations to Health and Disease. By T. Michell Prudden, M. D., author of The Story of Bacteria; Dust and Its Dangers, etc. G. P. Putnam's Sons, New York, 27 W. Twenty-third street; London, 27 King street, Strand. The Knickerbocker Press. 1891.

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WILLIAM DEAN HOWELLS,

The new Editor of the Cosmopolitan Magazine.

Buffalo Medical and Surgical Journal

Vol. XXXI. JUNE, 1892. No. 11.

Original Communications.

DIAGNOSIS AND TREATMENT OF ABSCESS OF THE ANO-RECTAL REGION.[1]

By EDWARD CLARK, M. D.,

Lecturer on Diseases of the Rectum in the Medical Department of the University of Buffalo.

I have accepted the courteous invitation of our presiding officer to read a short paper tonight, not because I hope to say much that will prove of very great interest to you, but for the reason that, as a member of this association, I feel that the presentation of a paper of some sort occasionally is a duty which we owe to our fellow-members and to the association; and although we may not offer anything new or original, we should, at least, be willing to contribute our mite toward the discharge of our duty, even if our contribution be only a review of some subject intended merely to elicit discussion by the members of our association. I desire, therefore, with the latter object in view, to make an attempt to discharge my duty tonight by calling your attention, briefly, to the consideration of some points connected with the diagnosis and treatment of abscess of the ano-rectal region. I have chosen this subject as the basis of my remarks for several reasons which I may mention: 1. These affections present themselves to our attention in considerable variety, and from their great frequency and the discomfort they produce, constitute a subject fraught with great interest to the surgeon. 2. They pursue, in a vast majority of cases, a very unsatisfactory and tedious course if left to themselves, or if treated in a haphazard and tentative manner, as they frequently are treated by those who make pretension to the possession of special knowledge and fitness for the treatment of rectal affections. 3. The recognition and management of these affections fall properly within a special field of practice, viz., rectal surgery, to the study and cultivation of which I have for a long time exclusively devoted my

1. Read before the Buffalo Medical and Surgical Association.

attention. I have alluded to the fact that abscess in the ano-rectal region presents a number of varieties; hence we find the text-books speaking of marginal abscess, fecal or rectal abscess, more properly known as ischio-rectal abscess and pelvi-rectal abscess. French writers were the first to describe marginal abscess as a distinct variety. This variety is very common, and we most frequently find them resulting from inflamed external hemorrhoids, in which case they are liable to be followed by a slight form of fistula. This form of abscess, however, originates in many ways other than in inflamed hemorrhoids. It sometimes begins as a small furuncle, or boil, in one of the mucous follicles at the margin of the anus. Suppuration of slight cracks or fissures near the anal margin may give rise to it. I have known it to occur from ignorantly injecting an external hemorrhoid with substances intended to effect a cure. Finally, it may be caused by traumatism, or exposure to wet and cold. This form of abscess is generally small and circumscribed, occurring more frequently in men than in women or children. It generally runs a rapid course, and is of no great consequence, except in tubercular or syphilitic patients, in whom it is sometimes followed by marginal ulceration of the anus, which sometimes requires much time and patience to bring up to a perfect cure. When these abscesses are in the formative stage, they produce a good deal of pain and discomfort, owing to the high degree of sensibility which is always present in the region in which these little tumors occur, leading the patient to think that he is suffering from an affection of great gravity. Early and free incision relieves this pain, and this, of course, is the proper treatment.

Ischio-rectal abscess, or the second variety found occurring in the ano-rectal region, is an affection of great importance, for upon its prompt recognition and proper management rest very largely the preventive treatment of that disagreeable malady, fistula-in-ano.

This variety of abscess takes its origin in the loose web of connective tissue and fat surrounding the lower end of the rectum, filling in what is known as the ischio-rectal fossa. This favorite locality for abscess presents all the facilities for the development and rapid spread of purulent collections. And when we take into consideration its anatomical structure and location, we can readily understand why an abscess in this situation attains such an enormous size before external fluctuation manifests itself, or even before the pent-up matter finds its way into the rectum.

I shall not weary you by going into the etiology of these cases, as you are all familiar, no doubt, with the many causes of these troublesome abscesses. The point I wish to emphasize is, that early diagnosis and proper management in these cases are of far greater importance than many of our profession seem to imagine. I am irresistibly inclined to make this statement for the reason that during the past year I have treated no less than five cases of severe fistula resulting from ischio-rectal abscess, which result, according to the clinical history in nearly all these cases, could probably have been avoided if the management of them had fallen into proper hands. I think I am quite safe in asserting that fully fifty per cent. of the fistulæ that we meet with following this form of abscess, could be prevented by early diagnosis and early and energetic management. If this statement is true, it will be readily seen that the treatment of ischio-rectal abscess is a subject well worthy our best thought and attention. When a patient comes to us presenting the symptoms of ischio-rectal abscess, we should lose no time in making an early diagnosis if such condition exists. In order to do this, rectal exploration is absolutely necessary, for, by this means, we can recognize in many cases the presence of deep-seated suppuration in the ischio-rectal fossa long before external fluctuation manifests itself. He who waits for external fluctuation until the patient's buttock becomes brawny, red, and tender, until rigors, fever, etc., manifest themselves, he who waits, I repeat, for these things before resorting to rectal exploration, shows an undue want of familiarity with the proper handling of these cases, and his delay in taking decisive steps to arrest the progress of the affection may give rise to extensive destruction of pelvic tissue, which may cause putrid absorption, involving danger to life. If we are not successful in our first rectal examination, we should repeat our explorations at short intervals, for it is only by timely recognition of the presence of pus that we can hope to succeed with our preventive treatment, which is the great desideratum in the management of these cases. To show the deleterious results of delay, and a masterly inactivity, or perhaps I should say ignorance, in cases of the affection under consideration, I wish to refer briefly to the clinical history of the five cases which I have alluded to above. These patients all consulted me for treatment for fistulæ of recent formation following abscess, and, as my note-book reveals the fact that the cases were all very similar, I will say that the history given by each patient was like unto the following:

A few weeks or months ago, had pain in vicinity of the rectum; at first slight and indistinct, then gradually growing more severe, especially during the act of defecation. Soon there appeared a slight hardness or induration in the buttock close to the anal aperture. Pain increased in intensity, and began to assume a throbbing character, and was soon so severe that standing, walking, or sitting were quite painful. Was compelled to take to the bed and call in a physician, who gave medicine to relieve pain, and applied tincture of iodine locally to "scatter" (?) the swelling. Pain constantly increasing, of a heavy, throbbing character, accompanied by fever and restlessness. As swelling could not be scattered, poultices were applied, but no use made of the knife. The patient, in answer to a request that the abscess be opened, was told that if any cutting were done a fistula would surely result! After ten or twelve days of intense suffering, the abscess finally broke. Weeks have come and gone and the abscess cavity does not heal, but continues to discharge a purulent matter, which creates a vast amount of local irritation.

It would, perhaps, seem that the above picture is overdrawn, but it is not, and the fact that in one year five cases of ischio-rectal abscess were so grossly mismanaged by men in this city who are doing a large practice, would seem to indicate an absolute necessity for even the much ridiculed specialist in rectal diseases. But to go back to first principles: Given an ischio-rectal abscess, how shall we treat it? The plan that I follow in these cases is as follows: Give the patient a brisk cathartic, and when it has fully operated, wash out the rectum thoroughly with repeated hot enemata. Administer an anesthetic, and when your patient is fully under its influence forcibly stretch and paralyze the sphincter ani muscle. This step of the procedure is very important and absolutely essential to success in these cases, for, in no other way can we secure perfect rest for the parts after operation. It is well known that the alternate contraction and relaxation of the sphincter muscle is a great hindrance to the ready healing of abscesses in this particular locality. Now, take a long, sharp bistoury and lay open the abscess cavity freely, cutting always through the integument outside of the sphincter muscles, the line of incision running at right angles to the nearest point of the anal margin. Introduce the finger or a scoop into the abscess cavity and thoroughly clean it out, breaking down all bands or pockets so that we have one cavity only. Now, syringe the cavity freely with a hot antiseptic solution, put in a drainage tube, or fill the abscess cavity loosely with a long strip of iodoform gauze, allowing it to hang out of the incision to keep the wound

open and secure thorough drainage. The cavity should be cleaned daily, and the drainage tube shortened from time to time as the healing proceeds. Keep the patient in bed on a nourishing diet, and in a week or ten days he will be entirely well with no resulting fistula. In speaking of treatment, some authors recommend that the abscess be opened from the rectum. I am of the opinion that this is a process not to be recommended, for we then convert the abscess into a blind internal fistula for the time being, and as such it is likely to remain for a long time, for blind internal fistulæ are more difficult of treatment than either of the other varieties. It will probably be urged by some that this is a very heroic plan of treatment for so slight an affection as ischio-rectal abscess. They may say that it is only necessary in these cases to lay open the abscess and let the patient go about his business, and that it is arrant nonsense to anesthetize a patient and stretch his sphincter ani muscle for such a trifling condition. In answer to such criticism, I would say that experience has shown that ischio-rectal abscess is by no means a trifling affair. It is well known that it frequently leads to severe forms of fistula which may leave the patient a miserable invalid for years, and the plan of treatment I have outlined is our only safeguard against such disastrous results. Opening the abscess freely and scooping it out, as recommended by many, is not sufficient. I am satisfied that stretching the sphincter muscle is the most important step in the management of this affection, for it is only by resorting to this procedure that we can put the parts absolutely at rest, which must in all cases be done in order to prevent the formation of fistulæ and sinuses. That this radical treatment is a necessity is very forcibly brought home to my mind by the cases above alluded to, and more particularly by a case which came under my observation a short time ago, photographs of which I was able to obtain, and which I take pleasure in showing you tonight. The patient, a very intelligent and well-to-do young man, about twenty-five years of age, had an ischio-rectal abscess a few years before I saw him, which was treated on the expectant plan by one of those physicians who thought lightly of the young man's affliction. He poulticed and painted, and waited, and finally after nearly two weeks of intense suffering, the abscess ruptured spontaneously. The patient's physician assured him that now his troubles were over. He allowed him to get up and go about. After discharging freely for a few days, the abscess cavity apparently closed up. In a short time it filled and was allowed to

break again. Things went on in this way for a long time, until the young man's buttocks were fairly riddled with sinuses and he became weak and emaciated,—in fact, a veritable invalid. About this time he placed himself under the care of a noted surgeon in New York, where he was at the time, who tried to bring about a radical cure. The ravages of the disease had formed so many fistulous tracks which required opening up, that the result of the operation was disastrous. Here was a strong young man left with permanent incontinence, owing absolutely to the neglect which was attendant on the management of the case during the abscess stage.

All authorities on rectal surgery emphasize the gravity and importance of the condition under consideration, and its liability to result in fistula when improperly managed. VanBuren has cited a number of cases in confirmation of this fact, one of which I take the liberty to quote :

> A very busily-employed executive officer in a heavy financial institution, sitting all day and living a little too well at home, was a victim of one of the most extensive abscesses of this sort I ever saw. His health had always been excellent and he was in the prime of life, but the abscess which formed in midwinter proved to be the cause of his death. Its formation and progress were insidious and slow, and its opening was long deferred and then not made sufficiently free ; and when I saw him in consultation there was an extensive cavity extending nearly around the circumference of the bowel, and he was suffering from hectic fever, which, as you know, is good evidence that the vital powers of a patient are unequal to the repair of his disease. We succeeded, however, in improving his condition so that he could have undertaken a sea voyage with a good prospect of ultimate cure ; but he refused to abandon his business and died exhausted during the subsequent midsummer heats.

Allingham, who has had so large an experience at St. Marks' Hospital, in London, states that out of 190 persons suffering from ischio-rectal abscess, 151 had terminated in fistula.

Curling, Ball, and others, all unite in saying that unless properly and energetically treated, the form of abscess under consideration is very liable to be followed by fistula.

In speaking of the treatment of these abscesses, a celebrated author says :

> The surgeon should make an early and free opening with the knife through the integument and follow it with his finger, so as to secure a direct and sufficient outlet, not only for pus but for sloughy *débris*.

This affords the only assurance of safety. When it is neglected, extensive surface ulceration and sloughing are liable to follow, with an amount of destruction of pelvic tissue around the lower end of the gut, which is often irreparable, and where the patient does recover he is liable to permanent disability.

A more severe form of abscess, so far as prognosis is concerned, than the latter, is what is known as abscess of the superior pelvi-rectal space, but, fortunately, this variety is more rare than ischio-rectal abscess. When we consider for a moment the anatomical bearings of the pelvi-rectal space, it can be readily understood that an abscess in this locality is a serious affair, indeed. We can see from a review of our anatomy why it is that an abscess in this locality assumes sometimes such vast proportions, burrowing into the connective tissue of the illiac fossa or anywhere else in the pelvic basin. These abscesses have been known to discharge into the vagina, bladder and rectum, and they may point in the loin, groin or gluteal region. They may cause urinary retention and fecal obstruction. The etiology of these abscesses comprise all the known causes of ischio-rectal abscess together with parturition (injury by pressure of the fetal head or blood-poisoning), diseases of the urinary organs, notably gonorrhea, acute prostatitis, urethral rupture with urinary extravasation, and the introduction of foreign bodies. An interesting case was recorded a few years ago by a French writer, where a hairpin had been introduced into the rectum, which subsequently worked its way into the sigmoid flexure, and after two years formed an abscess which opened first in the lumbar region, then over the trochanter major, and finally in Scarpa's triangle. This case was supposed to be one of hip-joint disease, but an operation revealed the error in diagnosis. On account of the obscurity of the symptoms, the diagnosis of this form of abscess is sometimes very difficult. Under this head Kelsey says: "The diagnosis of deep pelvic abscess will not often be made before the tumor becomes apparent or the pus has discharged itself. After a few days of sickness a hard, painful tumor appears in the lower part of the abdomen, or a free discharge of pus takes place from the rectum or bladder, and the cause of the previous symptoms becomes apparent. The rupture may occur into the peritoneal cavity, and a general peritonitis result, though in men the tendency is rather downward along the rectum to the perineum. Careful digital examination of the rectum will often render an otherwise obscure case perfectly plain. Even when the diagnosis of pelvic

abscess has been made, it may be impossible for a time to decide upon its origin, for psoas abscess, abscess from hip disease, perityphlitis, periproctitis, perinephritis, and inflammation in the connective tissue of the illiac fossa, may each cause a collection of pus in the pelvis. After pus has been obtained, should the origin not be plain, a microscopic examination for bone tissue may make it so."

The prognosis of this form of abscess is necessarily somewhat grave. Statistics prove that about twenty per cent. of the cases terminate fatally. Where the patients do not die, they are frequently left in a crippled condition, on account of the extensive burrowing of the abscess, resulting sometimes in permanent fistula and sometimes in rectal stricture, caused by cicatricial contraction. Ségoud, who has collected some important statistics regarding the termination of these cases, states that out of 112 cases,

> Thirty-five perforated the urethra, and seventy-seven, other parts, generally the rectum, but occasionally the perineum, the ischio-rectal fossa, and the obturator foramen. Twenty per cent. are fatal, and many leave fistulous communications with the urethra and rectum which are never cured.

The treatment of these cases consists of free evacuation of the pent-up matter, together with the use of antiseptic washes and perfectly free drainage. The patient should be built up by a nourishing, generous diet, cod liver oil, iron, hypophosphites, etc. A change of climate, and, in some cases, a sea voyage, may be followed by beneficial results.

271 Franklin Street.

Potassium Iodide in the Diagnosis of Phthisis.—An observation, which a few years ago was made by Sticker, is being confirmed recently by the same author, in regard to a peculiar action of potassium iodide in doubtful cases of phthisis. It appears that, in instances of this disease, when no rale or blowing murmur is detected at the apex of the lung, the seat of the lesion, small doses of the drug gave, in a few days, rise to the appearance of wanting signs. The medicine seemed to stimulate secretion, especially in the neighborhood of dead tissues, thus producing rales. In four cases of suspected tuberculosis, where negative results were obtained from physical examination of the lungs, the ingestion of the potassium salt, for purposes of diagnosis, produced distinct signs of localized reaction.—*Columbus Medical Journal.*

DOES ORGANIC DISEASE OF THE HEART PRECLUDE THE USE OF CHLOROFORM IN PARTURITION?[1]

By T. RIDGWAY BARKER, M. D.,

Demonstrator of Obstetrics in the Medico-Chirurgical College, Philadelphia; Out-door Obstetrician to the Pennsylvania Dispensary.

In entering upon the discussion of a subject of such paramount importance to mother, offspring, and obstetrician, one cannot lay too much stress, at the very outset, upon the axiom that "A good remedy will fail of its effect if not properly administered." This fact must be kept uppermost in our mind if we would avoid fatal results, not due, however, to the employment of the agent, as some would make it appear, but to the lack of attention and care exercised in its administration. That there is a radical difference between surgical and obstetrical anesthesia (analgesia), goes without saying. If we consider for a moment the stages of anesthesia, which differ only in the profoundness of the impression—first, sopor; second, stupor; and, third, stertor—we cannot fail to notice that in analgesia one rarely has occasion to carry the effect beyond the first degree (sopor), while in the surgical variety we are obliged to advance beyond this and keep the patient in the second stage, or that of stupor, thus markedly increasing the gravity of the prognosis.

In this connection, let us devote a moment's consideration to the progressive effect of chloroform vapor upon the nerve-centers of the cerebro-spinal system, beginning, as it does, at the inferior extremity of the cord, sacro-lumbar, and gradually extending its paralyzing influence upward until it reaches and expends its force upon the medulla oblongata. These well-established clinical observations having been verified by physiological experiment, we are justified in putting them to practical use. What other agent, may be pertinently asked, can relieve—aye, abolish—pain so quickly and safely, yet leave reflex muscular contractility unimpaired, as chloroform? Ether and ethyl bromide have found favor with some practitioners, but neither can displace chloroform.

Fordyce Barker states in his writings: "I may say here that I have long regarded chloroform as the best and safest anesthetic in obstetrics, and that since 1850 I have used no other."

The danger from the employment of chloroform in this department of medicine depends more upon the carelessness with which

1. Read April 27, 1892, at the meeting of the Philadelphia County Medical Society.

it is administered than to any toxic effect inherent in it. The four cardinal points to be borne in mind when giving this anesthetic are: First, plenty of pure atmospheric air; second, liberation of a small amount of the vapor at a time; third, attention to the respiration; and, fourth, frequent observations as to the force and frequency of the cardiac action. That the recorded cases of death have been due, in a great measure, to saturation of the residual air in the lungs to a fatal degree can scarcely be doubted. A few deep, forced inspiratory efforts will quickly produce such a condition. Withdrawal of the agent, under these circumstances, cannot prevent the further entrance of the chloroform vapor into the circulation, for it already fills the air-cells. Nor will attempts at artificial respiration prove effectual, since but a small quantity of the residual air can be forced out of the lungs, while that which enters fails to sufficiently dilute the vapor, owing to the tardiness of diffusion. Let us not suppose, however, that because we administer to the parturient female small amounts of the drug continuously, therefore no risk is incurred, for experiments directed to solve this important question go to prove that even small doses, when continuously inhaled, tend to produce dangerous, and, at times, fatal cardiac exhaustion. Far different is the result when given intermittently, as is the unalterable rule in obstetrics. Should we seek authority for the statement that the dangers from the careful administration of chloroform in labor are too insignificant to warrant its refusal, we have only to turn to the *American System of Obstetrics* to find therein the following: "The danger, when chloroform is used only to the extent of mitigating or abolishing pain in childbirth, is practically *nil*." Lusk, quoting from Bert's experiments, states "that chloroform might be intermittently administered for an indefinite period with safety." These remarks do not apply to its use in the third stage of labor, for, as is well known, after delivery of the child, it is likely to occasion relaxation of the uterus, thus favoring post-partum hemorrhage.

Offering the above as a preface to my remarks on the judiciousness of employing chloroform when the parturient female suffers from organic cardiac disease, it now remains for us to consider the effect of parturition upon this enfeebled circulatory organ, thereby securing a scientific basis for our conclusions. In the first stage of labor we find the muscular contractions confined to the uterine muscular layers, and directed toward overcoming the circular fibers of the cervix, while in the second or propulsive stage not

only does the uterus exert its power to the utmost, but also the abdominal and respiratory muscles are brought into action by the will of the parturient in her efforts to expel the fetus. The diaphragm is forced down and its movements paralyzed by the female holding her breath.

The other respiratory muscles are likewise unable to act, and, hence, imperfect oxidization of the blood results. As a consequence, the cardiac movements are accelerated, greater resistance is met with in the pulmonary and aortic circulations. Moreover, a tendency exists to venous congestion, as evinced by the hue on her face and swollen veins.

Owing to the excruciating pain experienced when the head passes through the cervix, the parturient is further tempted to make additional muscular efforts, which only augment the difficulties met with. Under normal conditions this strain is of such brevity that it cannot be considered of any importance, but when complicated by disease of the heart it is of far greater gravity. If the condition be one of fatty degeneration due to a previous perior myocarditis, resulting in faulty nutrition and enfeeblement of the heart's action, as evinced by weak impulse, venous stasis, confused and irregular sounds, anemia alike of the brain and other organs, with faintness and oppression on the slightest exertion, this interference with circulation and respiration may readily tax its powers too far, and so cause speedy death from paralysis. Here the conditions which pertain in surgical anesthesia are absent. The indications present are to allay excessive muscular action and respiratory spasm which is threatening the over-stimulated heart.

To allow the woman to continue such efforts is to permit her to commit suicide; to warn her to desist is useless when in such agony; while delay is likely to be fatal. How can we overcome this condition of nervous excitement? Can we accomplish it by the administration of chloroform? Yes; of the two evils, for we must acknowledge that there is an element of risk in giving chloroform, we can only choose the lesser, and so promptly proceed by inhalation to relieve the accessory muscles of parturition of their strain. By the abolishment of pain we lessen the work required of the laboring heart, which, instead of beating at the rate of 140 or more a minute, may diminish in frequency to 90 or 100.

What has been said of fatty heart is equally applicable to conditions of hypertrophy and dilatation.

The equilibrium, if disturbed, is almost certain to result disastrously. That sense of fulness in the chest and oppression due to bronchial congestion, if relief is not afforded, becomes most distressing. The cyanosis from deficient aëration is greatly exaggerated, while the insufficient blood-supply to the brain causes syncope, and may be succeeded by coma, if the excessive reflex disturbance be not removed. Nor are the indications for the administration of chloroform materially different in the case of females in labor with valvular disease. Whether it be mitral in the young adult or aortic in the aged primipara, the cardiac strain must be relieved if we would save our patient. As is well known, all forms of valvular disease ultimately develop a condition of ischemia on one side with corresponding low tension, while on the other side is stasis with high tension. While by compensation life may run on for many years, yet, when the strain of parturition comes, it will soon be overthrown if precautions are not taken to prevent it.

Of what benefit will be our knowledge of the value of cardiac "physiological rest," as laid down by Fothergill, if we do not apply it under these conditions ? We all appreciate the importance of securing "quietude of mind and body" when such pathological states exist. Then, why not employ the quickest and safest means to obtain it by the inhalation of chloroform ? If the danger is great from "active exercise,—climbing mountains, running upstairs, lifting heavy bodies, and all kinds of exercise involving heart strain,"—how much greater, aye, how immeasurably so, must it be when the parturient female forces, with the anguish of despair, every muscle to its utmost in her desire to deliver her child. From a study of chloroform anesthesia in obstetric practice we have seen how it should be administered and how it acts. Surely none will deny that in its employment under these circumstances we act otherwise than for the best interest and safety of our patient. That one may not be charged with being a blind adherent to theory, one has only to turn for support and justification to the teachings of the late lamented Fordyce Barker, who states:

> It seems to be almost accepted as an axiom, with both the profession and public, that the inhalation of chloroform is dangerous for any woman with disease of the heart. For more than thirty years I have been convinced that this opinion is quite erroneous, and I have so taught in my lectures and in former writings.

He goes on further to say : "I have seen several cases, complicated by dangerous heart lesions, which terminated favorably, as I think, solely from the use of chloroform."

Snow, likewise, is of this opinion, "In all forms of valvular disease," he says, "chloroform, when carefully administered, causes less disturbance of the heart and circulation than does severe pain." To quote from Championnière: "If," he says, "I recognized an organic affection of the heart, without pulmonary complications, I should rather give the woman chloroform than to let her suffer." Were further proof necessary as to the propriety of employing chloroform anesthesia, one might include among this group of clinical observers, Vergeley, who expresses himself thus: "Diseases of the heart are not a contra-indication to the use of anesthesia." Macdonald states: "In almost all cases of heart disease with labor, chloroform has been given, and apparently with benefit, during delivery. If carefully administered, I think, it cannot but be useful in all cases." Since such eminent authorities advocate its employment, can we justify ourselves in refusing our patients the benefit and comfort this agent affords? What is the danger from chloroform compared to the state of exhaustion and collapse into which the parturient female will inevitably fall? If this heart is forced to the verge of paralysis from overwork and excitement, why shall we not use the means at our command to lessen that strain? Let us have a reason for the faith that is in us, and not hesitate to fearlessly employ extreme measures to overcome extreme dangers.

Chloroform, by inhalation, can, and will, if properly administered, save the lives of parturient females suffering from organic disease, when death seems imminent from over-stimulation of its ganglia through reflex nervous action. Organic heart disease, then, does not preclude the use of chloroform in labor, but rather is a condition calling for its careful administration.

Aristol for Bed-sores.—Dr. J. W. Brooke (*Medical Bulletin*), reports the most gratifying effect obtained by him from the use of aristol for bed-sores in a woman aged sixty-two years, who was confined to bed by a fracture of the femur. The condition had existed for some time, and in spite of every precaution, sloughs began to form on both buttocks. An ointment of forty grains of aristol to an ounce of cosmoline, spread on old linen, was applied, with the result that within forty-eight hours all pain disappeared, and within a week all inflammation was allayed.—*Medical Fortnightly.*

INERT TUBERCLE BACILLI—OTHER MORE DANGEROUS ORGANISMS IN THE SPUTUM AND LUNGS.

By F. J. THORNBURY, M. D., Buffalo, N. Y.

Kitasato was recently assigned, by Prof. Koch, the work of cultivating tubercle bacilli from the sputum, and contents of closed tubercular cavities.

As well known, many, and the French in particular, have rather doubted the possibility of cultivating tubercle without first passing it through the body of animals. The cultivation, however, can be accomplished without this re-inoculation, although it is attended with difficulty, by reason of the slow growth of the tubercle bacillus and the luxurious development of other germs from the mouth. Koch's suggestion of using the early morning expectorate was employed, and from the receptacle containing some of this sputum, the numular, cheesy particles coming from deep in the lungs were fished out and deposited in Petrie's shallow plates containing water. These isolated particles are washed carefully in ten successive Petrie's glasses. In this manner all the organisms which have become adherent in passing through the mouth, are removed. The sputum is then teased in the Petrie's glasses under sterilized water, and a particle taken from the middle, a nodule, is stained and examined under the microscope to determine if tubercle bacilli are actually present. Very often they are, and then it is only necessary to transfer a particle of the sputum on glycerine agar or blood serum to obtain pure cultures of the bacillus. The cultures from the sputum differentiate themselves in appearance at the beginning of their growth from the cultures of bacilli obtained from organs. In each instance, the colonies first commence to form in about two weeks, but they present an entirely different appearance. The sputum colonies occur as clear, elevated, translucent spots. In addition, they are moist, glistening and smooth,—much like the colonies of white yeast; while the colonies representing organ cultures appear from the first dry, insipid and nodular. Gradually this difference subsides so that after four weeks the contrast between the two growths is no longer present,—a consequence naturally to be expected, as the sputum is nothing else than the fluid expectorated from tubercular cavities. Kitasato has also been successful in obtaining from closed lung cavities, post-mortem, many other bacteria found associated with tubercle, and which seem to play an exceedingly important roll in the course of the disease.

Cultivation experiments further demonstrate the interesting fact that many of the tubercle bacilli found in the sputum and lungs are inert and quite harmless, although microscopically no difference from live bacilli is recognizable. The dead bacilli color just as quickly and intensely and cannot be discriminated morphologically. But the fact of their being inert can be demonstrated in the following manner : A quantity of the sputum, or pus from a tubercular cavity, is spread on the surface of agar and the tube capped. The sputum remains visable for weeks and the tube shows no tubercular growth, while others of the same series present colonies characteristic of tubercle.

A specimen of the sputum from the sterile agar-tube is now examined microscopically. Myriads of fine appearing, readily stainable tubercle bacilli will be seen. With the sputum containing these bacilli which have remained inert in the agar-tube kept in the incubator for a long time, guinea-pigs inoculated died in two weeks. *But not one of them showed a trace of tuberculosis.* This demonstrates *conclusively* that the vast majority of tubercle bacilli occurring in the sputum and lungs are *inert*, and that this loss of vitality is not recognizable microscopically as yet. With reference to the other bacteria associated with tubercle in the sputum, the presence of certain forms is constant and their pathological significance *must be inferred.* In fact, when the case comes to autopsy, the organisms which were present in the sputum are found disseminated in pure cultures *through* the lungs, and indeed, in one case, (in this instance a bacillus,) the previously seen organism was also found in pure cultures *in every visceral organ of the body.* Many varieties of these bacteria may be cultivated, which during life are constantly associated with the tubercle bacillus, and post-mortem, are found in *pure cultures* in the lungs. There are three forms discovered by Kitasato, two different streptococci and three micrococci. These organisms fluctuate in quantity, like the tubercle bacilli themselves, as shown by continuous microscopic *examination.* I have, myself, recently observed in examination of tubercular sputum, masses of streptococci and micrococci vastly in predominance of the isolated and scattered tubercle bacilli. These strange organisms show simply the *counter-stain* of methyl-blue, while the tubercle bacilli, themselves, *alive or inert*, take the fuchsine red, and have the usual characteristic appearance.

610 Main Street.

Society Proceedings.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

The President, John B. Roberts, in the Chair.

PNEUMONIA AND ITS TREATMENT.

By HIRAM CORSON, M. D.
Plymouth Meeting, Montgomery County, Pa.

[*Read April 13, 1892.*]

What is pneumonia? That question correctly answered, we will be prepared to treat it. Professor George B. Wood, of the University of Pennsylvania, one of the most accurate describers of disease and a practitioner of great eminence, to whose graphic descriptions of disease many of you have listened, says in his *Practice of Medicine*, that

Pneumonia has three stages, and is universally applied to inflammation of the lungs. In the first stage, the lungs are merely engorged with blood, and the air-cells partly filled with a sero-mucous, somewhat bloody effusion. In the second stage, a plastic extravasation has taken place, and the cells are filled with more or less concrete and bloody lymph. In the third stage, the place of the plastic secretion has been supplied by a purulent fluid.

Dr. Wood was a truthful man, had great opportunities in the Philadelphia Hospital to see the condition of the lungs in the different stages described by him, for they may all be present in a lung at the same time, when the disease continues to embrace fresh portions of it. In that I doubt not he is correct. But as the subject which now engages our attention is one of great importance, I beg you to bear with me while I quote from another author. Dr. G. R. Martine, of Glens Falls, N. Y., in a paper read before the American Medical Association in June, 1889, published in its journal September, 1889, — a paper remarkable for its accurate description of the disease as it exists in cases involving much of the lung, and for erroneous deductions in relation to treatment,— thus speaks:

The first abnormal symptoms, after the premonitory chill, is the quickening of the pulse and the consequent increased flow of arterial blood. Now, if we could take a microscopic view of the minute arterial ramifications in the lung structure, we would discern a distention in the caliber of the air-vessels in order to accommodate the augmented flow of blood; and if we would then glance at the veins we would

observe the plasma layer rapidly filling with white corpuscles, and the walls of the veins, irritated by the friction of increased circulation, would exhibit, here and there, white corpuscles adhering to their tenacious sides and finally penetrating their walls. A glance at the capillaries would show not only the white, but also the red corpuscles forcing their way through the overstrained capillary walls until the surroundings became engorged by their extravasation, and hepatization has commenced.

Now, if we bear in mind the condition of the lungs as described by the writers, we must believe that pneumonia is first a congestion, then an inflammation, and if that be not arrested suppuration takes place. Dr. Wood says: "It has been doubted whether a cure is ever effected in this last stage."

We are now brought face to face with the disease. Is there anything we can do to remove the congestion? The patient has been sick less than twenty-four hours, he is not yet expectorating bloody sputa, and many of the opponents to blood-letting say this disease cannot be aborted; that, like measles, it has a course to run, despite all interferences; that it is a constitutional disease, and that if we can prevent the congestion from being too suffocative, the inflammation from involving too much of the lung, we may let it run its course. The members of our profession are divided into two classes: those who believe that the disease may be aborted, *i. e.*, arrested in the congestive stage if early called, and in the stage of inflammation before suppuration has taken place; and the much more numerous class, who believe that it cannot be aborted; that a case, even if it be in its incipiency, must go on,—should be watched by the physician, and shorn of its power to take life, but be allowed to go on until a crisis is reached after a positively fixed number of days. Physicians of the first class aim to relieve the overloaded and suffering lung by the abstraction of blood by means of the lancet, from the veins of the arm; and those of the second class, who boast that they "never bleed" in any disease, depend on giving relief by reducing the increased action of the heart with medicines which have that effect. But the members of this latter class are greatly divided in opinion as to the proper medicine to be used to hold the heart in check; what one regards as being very useful and safe, another considers dangerous,—more dangerous than the disease, and withal inefficient,—yet all speak from experience, each one with his remedy. Experience is a harmful thing as a reason for continuing to practise a certain course, unless it has been successful experience. It reminds me of a case: I had attended

a woman in her confinement, and as she expected to have the child raised by hand, as the phrase goes, and had read my paper on Food for Infants, she desired me to speak to the nurse about her mode of feeding the child ; so, when she appeared, I said : "Nurse, do you know how to feed a child so as to rear it without the mother's milk ?" "Oh, yes ! I have had experience in doing that ; my sister had three that I had to raise that way." "Well, how did they come on ?" "Oh ! very well ; one of them lived until it was six months old." Who among us but can look back on measures which we practised, and which we believed indispensable because we had proved them, as we thought, by a long experience, but which we now see were not only useless but injurious. This, then, successful experience in the treatment of pneumonia is what we should follow. The absence of success, the fearful mortality attending the arterial sedative practice of the "no blood to spare" party ; the immediate relief, the successful arrest of pneumonia by blood-letting, during a whole century, should cause the opponents to venesection to cease their abuse of those whose successful experience in the use of it has been testified to by some of the most eminent men of this city and this country. A few weeks ago I was told by a gentlemen, holding a high State office, that a physician of whom he inquired concerning the recent death of a prominent man, replied: "Oh ! he was murdered by blood-letting." Does this man, who speaks so boldly about a measure of relief, of which he knows nothing from actual experience, who never used the lancet in his lifetime, denounce Prof. George B. Wood, Physic, Parrish, and the elder Hartshorne, Chapman, Samuel George Morton, Ezra Michener, Prof. Henry H. Smith, the Atlees — John and Washington — Traill Green, Henry Hartshorne, Jackson, of Northumberland, N. S. Davis, Prof. S. D. Gross, and hundreds of others who could be named, as conscientious as himself and far more truthful ? We have borne this stereotyped abuse long enough. Look at the terror spread over the country now, when these numerous deaths of the best of our people are every day announced, though all were in the hands of practitioners skilled in arterial sedation. Let us now see what the opponents of blood-letting resort to, to save the sufferers from death in this disease. From what I have learned of the present teachings in our colleges, and by conversations with practitioners, the main object is "to keep down the pulse"— that is the phrase. To do this, the most approved medicine is the fluid extract of veratrum viride.

"The object aimed at," says Dr. Martine, "is to hold the pulse below eighty;" and adds, "*that* is not only what should be done, but what *must* be done to save life." I know full well *that* is not necessary. Scores of times, after I have bled freely, with great relief to the patient and arrest of the disease, the heart, though tamed by the bleeding, continued its pulsations at from 80 to 100 per minute, or sometimes even more, for two or three days, and yet the convalescence went on. Again, he says: "With what remedies do I hold the pulse at this point (below eighty)?" and adds "veratrum viride seems to have served one best." To this, Dr. H. A. Hare, who was present at the reading, replied: "A great mistake is made in saying use cardiac sedatives in pneumonia without recognizing the fact that they are to be used only in the first stage, before congestion has gone on to consolidation; the man who gives such drugs at the middle or end of an attack of pneumonia, might as well stab his patient. Digitalis is to be used at such times." It therefore appears that it is only in the congestive stage that veratrum is to be used. If this be true,—and doubtless it is based on experience,—how many patients have been sent to their graves by this much-used medicine! for well do we all know that it is the most used of all arterial sedatives to keep down the pulse. And even Dr. Martine has peremptorily declared that it must be kept down, and that veratrum viride seems to have served him best. But it is not only Dr. Martine who disregards the stage of the disease, and uses it in all stages if the pulse be above eighty. I have long believed that nearly all the cases of pneumonia which terminated in death within four days, and I know several such, were hurried there by this potent and dangerous drug. Dr. I. E. Atkinson, of Baltimore, followed Dr. Hare, and said that "the use of veratria in the treatment was not new: it had been several years under trial, and had not received general acceptance." If Dr. Hare's utterances be true, then veratrum viride can scarcely be used at all without killing the patient, for a physician is seldom called until the congestion has passed into the second stage, when, according to Dr. Hare, you might as well stab the patient as to give it. How unerring must be the diagnosis, in order that this medicine may be given without risking the life of the patient. I have inquired of many of the "no blood to spare" class, and have rarely found two that have the same treatment. Those who use aconite are afraid to use veratria, while the latter regard aconite as being more dangerous and less efficient. Those, too, who use digitalis

are afraid of the two drugs just named, and those who give two drops every two hours denounce others who give large doses of it (ten to twenty drops, frequently repeated,) as pursuing a most dangerous practice. Judging from the accusations made by themselves against each other, what safety is there to the patient? The answer comes in saddest tones from homes made desolate by dangerous arterial depressants. To the two classes of opponents to blood-letting spoken of, there are others which should have a passing notice: first, those who rely on the use of sulphate of quinine to keep down the pulse and to diminish the heat of the body. While quinine is, in malarial diseases, an unrivaled medicine and has done valuable service, it is useless, if not really most injurious, in the treatment of pneumonia and other inflammatory diseases. We should feel greatly indebted to Dr. Horatio C. Wood for the experiments which proved to him that even very large doses of that medicine cannot hold the temperature of the body at a low figure. There was so much stress laid on the importance of preventing the heart failure, by keeping down the temperature by means of quinine above all other medicines, because of its tonic powers, that Dr. Ripley, the two Drs. Jacobi, and three other physicians of New York City, made careful and repeated experiments to determine the value of the drug in that respect, and demonstrated beyond cavil that it is never useful, and often greatly objectionable—really injurious—in the treatment of pneumonia. I have often felt exceedingly thankful to Dr. Wood and the New York doctors for their careful and effective labors in that direction, and greatly amazed that, in the face of the assertions that quinine is useless in pneumonia to effect the purpose for which it is used, some persons still persist in its use. Many lives have thus been lost. The second class of those who fraternize with the arterial sedative practitioners is composed of the whiskey or stimulant practitioners,—the physicians who see typhoid and blood-poison symptoms in almost all diseases. I will spend but little time with them. They are belated people, clothed in, and proud of, the cast-off garments of progressive physicians. Let us look calmly at this subject. Are there physicians here who can say that there are medicinal properties in whiskey or in brandy which, in either large or small doses, warrant us in trusting the life of a patient to their action? It is a serious thing to experiment with human life. No means but those which have proved successful in numerous cases should be used when our patients are struggling for breath, and

death hovering over them. There is nothing more saddening to me in the sick-chamber than to see a physician forcing alcoholic drinks on the dying patients, and yet it has been done countless thousands of times, and now ofttimes they are used in the very earliest stages of pneumonia. Dr. N. S. Davis does not believe them essential in any disease. If, then, arterial sedatives, quinine, and alcohol, are not adapted to relieve the congestion and inflammation of the lung, which constitute pneumonia, is there any remedy for that now fatal disease? We know that there is, but not from an experience like that of the nurse already named, nor of another one, greatly experienced, of whom allow me to speak. I was called to a child, lying on the lap of a friend, "because she had had experience with such cases." I said, "The child seems very sick." "Yes," she replied, "it has summer complaint, and it will die." "How do you know it will die?" "Oh! I have had experience; I have had ten of them with it." "All your own children? did they all die?" "Yes." "Did you have the same doctor for them all?" "Yes." "Well, your experience is worth nothing." I treated the child, and, to her disgust, it was soon well. Her experience is a fair type of the experience of those physicians who go on with the same fatal treatment, lose one patient after another, and speak of "experience" in treating the disease.

But now a word about those who "murder" their patients by bleeding them. What are the objections urged against blood-letting? and by whom? The first objection is, "No one has any blood to spare." If this be true, then it embraces all other objections, and none need be named. This certainly means that in health, as well as in disease, the loss of even a small quantity of blood would be injurious to the loser of it. It means more than that— means, as is boldly asserted, that it is a permanent injury to the body, the bad effect of which is seen in the permanently weakened system of the person. Thousands of facts disproving this, and which are daily before our eyes, count for nothing. One would suppose that if half a dozen, or even one, of the respectable, truthful men here should declare that he had often bled persons in various diseases with the greatest benefit to them, nothing more would be needed to prove the falsity of the declaration, "no blood to spare"— a cry so senseless, so false, that no decent man should utter it.

The very first act of these objectors after the birth of a child, in cases attended by them, is deliberately to cut the cord and waste

two ounces of blood that ought to have passed into the body of the child.[1] But there is another objection urged, viz., that even in the earliest stage of the disease under consideration, though some relief may be obtained, no blood should be taken, lest it should leave the patient too weak to resist the exhaustion of a later stage,—leave him in a condition in which even whiskey and rich food would, though *pushed*, not be able to save him from death.

Is it, then, injurious to take blood from a pneumonic patient?

This is the cry and the charge of those who have never seen a patient bled, and yet who have known its safety and value to be testified to by some of the most eminent physicians who have ever lived in this century or preceding ones. In my last four papers, published in the *Medical and Surgical Reporter*, I have given a few cases reported by the Conshohocken doctors, which were bled freely, and were so successful that opposition to venesection should be silenced in those who read them. I will now speak of some seen by myself, and in doing so will present some views which I have long held:

On February 16, 1887, I was called to see a physician two days after an acute, serious attack of pneumonia. I found that he was under treatment by one "who never bleeds in any disease." He was expectorating the bloody "rust-colored, prune-juice" sputa, a quantity of it being in the basin; had great oppression and that peculiar sense of great weakness so constant an attendant in pneumonia when the obstruction to free breathing exists. I had to wait nearly three hours for the return of the physician, and when he did come he was opposed to bleeding, and refused to accede to it, but proposed that the patient choose whether or not he would be bled. The patient knew well our different modes of treatment, and promptly said, "I will be bled." I asked the doctor to remain, and, slipping another pillow under the sick man's head, I drew blood until I found the pulse yielding in *force*, and knew that faintness was approaching. Withdrawing the pillow to lower the head, I closed the vein and took a seat. In about ten minutes I inquired, "How do you feel?" "I am much relieved; I think it will do me great good." This was at noon. Went again in the evening; he was pretty comfortable, breathed much more easily, and had not coughed up the least particle of blood or rusty sputum since the bleeding. The distended blood-vessels were relieved of their fulness, and "the slow exudation from the inflamed vessel" spoken of by Dr. Wood was no longer forced through their coats. Would one or twenty doses of arterial sedatives have produced that effect? Having bled my patient, what next did I do? Nothing, but told him that I would see him in a few hours.

1. See Transactions of the *Pennsylvania State Medical Society* for 1872, p. 154.

And here let me say that, in the case already alluded to, when I saw by the papers that he had been bled, I said, "in all human probability he will die!" "Why?" was asked. "Because he was *timidly bled by one unused to venesection and fearful of it*, and because the other depressing, arterial, sedative treatment will follow it, and the patient will suffer from their poisonous, depressing effects."

To return to my case: When I saw the patient a few hours afterward I found him pretty comfortable. I directed one Dover's powder, to be repeated in the night, if need be, because of pain. Next day a mild diaphoretic was administered.

Two days after this a physician who, as a neighbor, had given much attention to his sick friend, asked me: "How do you find your patient?" I said: "He is well; he needs only a few days in bed to regain his strength." I left for home, and he went to the patient and said to him: "The doctor told me just now that you are well. What was it that cured you? was it that blood that came from your arm?" He replied: "The blood did not come from my arm; it came from here," laying his hand on the affected side. "I felt it going from here as it went into the basin." How strong this testimony, given by a physician who felt in his own person the relief obtained by venesection! How confirmatory, too, is this of the testimony of Dr. Gross, the elder, who, in a discussion, had in the State Medical Society illustrated the effect of venesection in this way:

Should a man have an inflammation of the conjunctiva, and the capillary vessels be so injected that the blood was of a deep redness; and then he, being in a sitting posture, should be bled largely, the blood would be drawn from the capillaries, and the redness disappear. Just so does it draw the blood away from the capillaries of the congested and inflamed lung.

Veratrum viride in doses large enough to keep the pulse below eighty, would not produce the least relief to the distended capillaries. Having bled the patient, if in a few hours there is not much relief, he may be bled again, if needful, and even more than once. But what of local measures? Do I approve of the poultice or the pads of cotton to envelop the chest? No. Two years ago, after my criticism of Dr. Wells's paper was published, an aged physician regretted that I had not spoken of the value of "the blister" over the affected part. The subject before me was only that of Blood-

letting: Its Value or Danger. It is the same now, but I may add here that the application of cloths dipped in ice water is to the patient the most agreeable application that I have ever used.

Despite the great length of this paper, I beg of you to hear the utterances of one of our most eminent men to his students at his clinic in the University Hospital, and published in the February number of the *International Medical Magazine*, pp. 43, 45. Dr. William Pepper stated to his pupils at the clinic, that

> The man of twenty-eight years had been well until ten weeks before his admission to the ward, and had during that time been treated by several physicians. On admission, November 5th, his distress was extreme; he was unable to lie down or recline, and was obliged to remain constantly in a sitting position, but did not get relief from leaning forward.

Then follows a long and interesting account of the illness and treatment; after which follows:

> On November 7th, the third day of his stay at the hospital, the symptoms were so alarming, with deep cyanosis, labored action of the heart, orthopnea, and high fever, that I had him bled from the arm to the extent of twenty ounces. The good effect of this was immediate, and although cyanotic symptoms returned to some extent on the following day, a material improvement dated from the time of the venesection.

Again, the learned professor at great length gives his views of the case, and before closing his paper, remarks, January 5th:

> He has continued to do well, and is now thoroughly convalescent. Before closing, I would call your attention to the extraordinary effect which followed the abstraction of blood. All of us who saw his condition before the bleeding, and watched the immediate effect of this, were satisfied that his life was saved thereby. I doubt if any other remedy could have acted so promptly and efficiently. It was the observation of such striking results, when bleeding was used in suitable cases, that gradually led our medical forefathers to rely upon it more and more in grave crises, until its occasional and legitimate use degenerated into almost promiscuous abuse. It is one of the tasks set before clinical medicine today to indicate with the greater precision, rendered possible by our improved methods of investigation and more full knowledge of the natural history of disease, the exact conditions under which this most powerful remedial measure is to be adopted.

Such are the recent utterances of the able editor of *A System of Medicine by American Authors*, in which is a paper by Alfred Loomis, M. D., Professor of Practice in the University of New

York, who believes "pneumonia a constitutional disease, with a local manifestation," and regards blood-letting as a dangerous plan of treatment. Such, too, has been the views taught to large classes of students by Prof. Pepper, until he made trial of the remedy. I sincerely hope that Prof. Loomis, too, will make a trial of it hereafter, and be induced, like Dr. Pepper, "to doubt that any other remedy could have acted so promptly and efficiently."

I cannot be too greatful to Prof. Pepper for his valuable testimony in relation to venesection, and for the hope which he has given us, that hereafter he will not withhold this potential means of relief from those suffering in the grasp of this (now) too fatal affection. It is one of the most remedial diseases when properly treated; but when managed by arterial sedatives and their aids, stimulants and excess of food, a most fatal one. More than sixty-five years of careful, anxious observation of the effects of blood-letting in pneumonia have proved to me that it has no rival as a remedy for that disease.

NEW YORK ACADEMY OF MEDICINE. SECTION ON ORTHOPEDIC SURGERY.

Stated Meeting, April 15, 1892.

HENRY LING TAYLOR, M. D., Chairman.

Dr. L. A. SAYRE said that in his paper at the last meeting, he had referred to a case of hip disease which he had seen in consultation with Sir James Paget and Mr. Adams, of London, which it was generally considered could not recover without anchylosis and deformity. He was fortunate in having the opportunity of presenting this patient at this meeting. This man could place his feet on a table, could squat down, and, in fact, could perform every motion so well that it was difficult to see which had been the diseased hip.

THE EFFECT OF PERSISTENT MOTION.

Dr. JOHN RIDLON exhibited a girl, nine years old, who had come to him at the Vanderbilt Clinic on April 23, 1891. Eight months previously she had received an injury to the right elbow, which was diagnosticated as a "fracture of the coronoid process of the ulna, and a dislocation backwards of the radius and ulna." She was attended by a well qualified practitioner of this city. The arm was immobilized for about four weeks, and then passive motion

was commenced. Twice daily the forearm was flexed and extended on the arm to the limits of tolerance, and twice weekly, under an anesthetic, the forearm was flexed and extended to the normal limits of motion. This treatment was faithfully continued for seven months, during which time the range of motion gradually became more restricted, the joint more and more swollen, and more painful under the attempts at motion. Examination showed the forearm flexed on the arm to a right angle, much swelling about the joint, enlargement of the superficial veins, and atrophy of the muscles of the arm and forearm. The swelling had a pulpy feeling, but no point of fluctuation could be detected. The bony points were so obscured that the exact nature of the injury could not be determined. There was no motion of the joint, and attempts at motion caused pain and developed intense muscular spasm.

The treatment adopted was as follows: The head was bent down, and the wrist put in a "halter" made out of a roller bandage, knotted around the wrist and neck. The slack of this was taken up as the rigidity yielded, and at the end of two weeks the joint could be completely flexed. In this position, the joint was held without motion being once permitted or tested for eleven months. The pain disappeared, the swelling gradually subsided, and, when the halter was removed, there was found to be free, painless motion, from a right-angle to normal flexion. Since then there has been no treatment, and the range of motion in the direction of extension is gradually increasing.

Dr. W. R. Townsend said that this girl had been brought to the Hospital for Ruptured and Crippled, about two years ago, by her attending physician, who said that passive motion had been made, under ether, about three times a week since the fracture, to prevent anchylosis. Dr. W. T. Bull, who saw the case in consultation, agreed with the speaker in advising rest. The attending physician dissented from this view, but finally said he was willing to give the joint rest for a limited time, if he were relieved from all responsibility as to the result. The case was accordingly treated in the hospital with a plaster-of-Paris splint for about four weeks, when the mother objected to a continuance of this treatment. Dr. Bull again saw the case in consultation, and the opinion was then expressed that there was a beginning osteitis, and that if motion were kept up, the child would undoubtedly have a stiff elbow. The patient and doctor dissented again, and wished

passive motion made, so she was then discharged from the hospital out-patient department.

Dr. S. KETCH said that if the arm were moved beyond a certain point, especially in rotation, there is reflex spasm, and he thought there was still some active disease in the elbow joint. He asked if the halter allowed of pronation and supination.

Dr. RIDLON replied that the halter did not prevent these motions, but, so far as his experience with it had gone, when properly applied under the clothes, the children, as a matter of fact, do not attempt to make these motions.

Dr. RIDLON also presented a case for diagnosis :

A man, thirty-four years old, came to him at the Vanderbilt Clinic, on February 15, 1892. For two weeks he had been stooping and stiff in the lumbar spine, with pain in the back and lower abdomen, and, at times, down the front of the thighs. Seven years ago, he had a similar attack, at which time, after suffering for four weeks, he went to the dispensary of an orthopedic institution in this city, where the diagnosis was made of Pott's disease, and a Taylor spinal brace applied. He remained in bed for two months, wearing the brace, but without any relief. He was then admitted to the St. Francis Hospital, where a blister was applied, and the pain immediately relieved. At the end of two weeks, he was quite well again, and remained so up to the present attack. Examination revealed the whole lumbar spine curved backward and rigid ; there was psoas contraction on the left side, but none on the right ; and there was a doubtful fulness in the left iliac fossa. He was treated with anti-rheumatic remedies, and soon showed improvement, and in the course of a few weeks felt entirely well. There is now no spinal curvature, no rigidity, no psoas contraction, and the patient is quite well, except that at times, after long sitting over a bench at his work, he feels the back somewhat stiff.

AN INEXPENSIVE HEAD SUPPORT.

Dr. ROYAL WHITMAN exhibited a support which he had devised for a child with mid-dorsal disease, in whom there was a tendency for the shoulders and the whole body to droop forward. The support consisted of a curved piece of steel attached to the back of the brace used in connection with lateral pads for holding the shoulders back, a form of apparatus which he had already exhibited and described.

Dr. V. P. GIBNEY then exhibited a series of operative cases.

ANCHYLOSIS OF HIP AFTER TYPHOID FEVER.

The first case was that of a boy, eleven years of age, whose trouble dated back to an attack of typhoid fever, in November, 1889. He was admitted to the hospital July 14, 1890, and at that time his general condition was fair; there was a long and deep cicatrix over the right hip. There was about half the normal motion. The left hip was held flexed at 135°, and there was much spasm. His mother died of phthisis, but the other members of the family were healthy. One month later, the right limb could be extended to 180°, and the left limb to 170°, with little or no motion at the knee. He was then allowed out of bed, wearing a brace on the left side, and a high shoe on the right. On November 19th, there was some tenderness around the joint, but none in the joint. The brace was left off, and he was given cod liver oil, and allowed to walk around. On January 16, 1891, the right thigh was flexed on the abdomen. The adhesions were broken up by manual force, and in doing so, a "snap" occurred. The tensor vaginæ femoris and the fascia were divided subcutaneously, when the deformity yielded visibly. The limb was then hyper-extended, abducted, and rotated outward, and put in plaster-of-Paris. On February 11th, as the thigh was flexing, the limb was placed on an inclined plane, with a weight and pulley, and this treatment was continued for nearly one month. The left hip was then extended at an angle of 158°, with practically no motion, and the right hip at 170°. On June 13th, the right thigh could be completely extended; the left to 140°. On October 23d, under ether, it was found that the hip could not be fully extended, so the tense bands attached to the anterior superior spine were divided, and then the limb almost completely extended, and put in plaster-of-Paris. On January 18, 1892, he was etherized, and a femoral osteotomy performed, and the limb hyper-extended and put in plaster, and by February 17th there was firm union, the limb was extended at an angle of 175°, and with 5° of motion. The ordinary hip splint was then applied. On March 5th, the limbs were parallel, union was very firm, and his general health was good. On April 6th, he was allowed to walk about without any support.

EXCISION OF ONE HIP IN A CASE OF DOUBLE HIP DISEASE WHERE SACRO-ILIAC DISEASE WAS FIRST DIAGNOSTICATED.

The next case, a boy, nine years old at the time of his admission, on January 22, 1890, had a good family history, and his hip

disease was attributed to a fall in September, 1889. Before coming to the hospital, he had been treated in a dispensary for sacro-iliac disease. At the time of admission, the thigh could be flexed to 60°, and extended to 180°; all the movements were restricted by pain. On March 4, 1890, both thighs and knees were flexed, and there was much reflex spasm about the right hip, and somewhat also about the left. The hips and knees were extended, and the limbs made parallel, and they were then put up in plaster-of-Paris spica. About this time, the temperature began to rise to 102° every night, and to fall in the morning to 98.8°, and there was marked tenderness in the right hip. On March 29th, there was fulness and deep fluctuation in the upper fourth of the thigh, and a needle withdrew some pus and blood. A hip splint was applied, and the child put to bed. On April 8th, a double spica with traction was applied. On September 3d, about seven ounces of pus were removed from the right thigh by aspiration, and on the 30th of the same month the child was etherized, an old sinus curetted and enlarged, and a counter opening made. The head and neck of the femur and the acetabulum were found to be diseased. The temperature remained high until October 15, 1890, when a large abscess was found over the trochanter major, which did not communicate with the sinus. On January 28, 1891, after poulticing, the abscess opened spontaneously. On February 10th, the child was etherized, and excision performed. The head and neck were curetted, a counter opening made, and a double spica applied. The dressings were changed every third or fourth day, peroxide of hydrogen solution being used to wash out the cavity. By July 2d, the excision wound was almost completely closed; there was some infiltration about the joint, but very little spasm and tenderness, and the limb could be extended to 180°, and flexed to 160°. By September 16th, flexion had been increased about 10° in the right limb, and the left limb could be extended to 180° and flexed to 135°, motion being slightly restricted by spasm. On December 16th, a jointed splint was applied, upon which he walked around with comfort. On February 27, 1892, it is noted that there is a fair amount of motion at the right hip, without pain, the other limb remaining unchanged since last note.

EXCISION OF HIP WITH FAIR RESULT, SCARCELY FINAL.

The next case was a girl who was eleven years of age at the time of her admission on June 6, 1889, with hip disease of six

months' duration. Her mother had died the previous year of some pulmonary affection. The child was poorly nourished, and could hardly stand ; the right limb could be flexed to 135°, and abducted one-fourth of an arc, and the left correspondingly adducted ; there was marked tenderness and spasm. On July 31, 1889, a small quantity of pus was removed by aspiration, and the hip splint was applied. On December 9th, of the same year, the limb was much abducted, and there was some infiltration in the upper part of the thigh. On May 13, 1890, the hip was very acutely inflamed, and the child had night cries, and tonics and stimulants were ordered. On December 2d, there was very little discharge, and the wounds looked healthy. On February 12th, four sinuses were discharging freely, and there was considerable burrowing of the pus. On April 24, 1891, excision was performed, involving three of the sinuses. The capsule was practically gone, and the head of the bone carious, and there was a shell of exfoliated bone. After dividing the bone at the neck, it was found that the disease extended into the shaft, so one and a half inches were removed, and the parts thoroughly curetted, packed, and drained. On July 18th, the child was etherized, and some sinuses again scraped out. On July 27th, there was ten degrees of motion, and the limb was extended to 170°. By August 20th, there was scarcely any discharge, no tenderness, the limb could be extended to 180°, and there was 20° of motion. On February 18, 1892, it was noted that the angle of greatest flexion was 100°, and greatest extension, 180° ; there was no spasm or pain on manipulation. At present she is wearing a caliper splint, the right thigh can be flexed nearly to ninety degrees, abduction is quite good, and extension is nearly perfect.

CASE FOR DIAGNOSIS, PROBABLY SUBACUTE RHEUMATISM.

A little boy was next exhibited, who had been sent to the outpatient department of the hospital about three weeks before for a diagnosis. For three months he had complained of pain and stiffness in the hips and knees. He had the walk of hip disease, with slight spasm, and slight limitation of motion, and it was a question whether there was really incipient hip disease, or whether there was a neurotic element in the case. He was given the salicylates internally. Soon after he began to complain of pain in the knees and ankle, while the hips had improved slightly. He had been in the hospital only two days, but in this time there had been some improvement. There was evidently pain, and, undoubtedly, also

an inflammatory process, as on several occasions his temperature reached 101 or 103°.

ATONIC KNOCK-KNEE; FAILURE TO RELIEVE BY APPARATUS; SUPRA-CONDYLOID OSTEOTOMY; SUBSEQUENT SYNOVITIS; LATER STILL, APPARATUS; RESULT, VERY UNSATISFACTORY.

The fifth case was a girl who first came to the dispensary on January 1, 1888, when fourteen years old. She then had right knock-knee, which was treated with a Thomas knock-knee splint. The brace was worn for about one year, and then was removed, and the shoe built up on the inner side. On August 5th, the knee had again become relaxed, and plaster-of-Paris was applied. On October 21st, there was a synovitis of the right knee, and the girl was admitted to the hospital shortly afterward. At this time both knee joints were relaxed, and could be hyper-extended; there was flexion to about 120°. The knee joint was distended with fluid, and there was some joint tenderness. On November 14, 1889, about twenty ounces of clear fluid were drawn from the joint, which was then irrigated with carbolic acid solution, 1.40, and the limb put up in plaster-of-Paris. On January 30, 1890, there was again some effusion into the joint, and she walked with some stiffness. There was flexion to 140°. On February 27th, she was discharged unimproved, and on March 31st, she was re-admitted. At this time there was marked lateral improvement, the tibia could be abducted so as to make an angle of 153° with the femur, and adducted to 175°; the knee could be flexed to 110°. There was also much pain in the muscles about the right hip and thigh, and considerable tenderness in the iliac fossa, with prominence just in front of the great trochanter. On September 18, 1890, the pain had disappeared from the hip, and she was wearing a Knight posterior knee brace. She was discharged from the hospital then, but again admitted on May 27, 1891. Finally a supra-condyloid osteotomy was performed from the outer side, and the knee over-corrected, and put up in plaster for awhile. At present she is wearing a splint without motion at the knee, and, although she walks well, there seems to be no prospect of improvement.

SOME OF THE INDICATIONS FOR OPERATIVE INTERFERENCE IN ORTHOPEDIC SURGERY.

A paper with this title was read by Dr. V. P. GIBNEY.

The paper dealt first with the range of orthopedic surgery as held by the majority of surgeons practising this specialty through-

out the world. It commented on the brilliant results obtained by general surgeons in many cases that were strictly orthopedic. It emphasized the importance of supplementing operative procedures with mechanical appliances.

It was suggested that orthopedic surgery might be advanced if one devoted as much time to the clinical history and the pathology of the disease which produces deformity, as one does to the devising of splints and modifications of splints. The importance of devising splints to suit individual cases, and to meet certain conditions, was regarded as an important part of orthopedic surgery.

It was stated that the orthopedic surgeon seldom has an opportunity of putting a splint on a case in the very first stage of the disease ; that many of the cases of what are called early hip disease were not early cases, but that deformity had already arisen when they came to mechanical treatment. The same was true of Pott's disease of the spine

Some of the indications for operative interference were mentioned as correction of deformity in these early hip cases by manual force under ether, by division of tendons and muscles, if the correction were difficult; and, in the advanced cases, where the disease was fully arrested, osteotomy below the trochanter minor was suggested as a valuable addition to our therapeutics.

With regard to abscesses, it was urged as good orthopedic surgery to make incision, if four or five aspirations failed to relieve. It was further suggested that old sinuses and pockets of pus should be treated by operative interference.

Operative interference in spinal disease was not recommended, except where a severe trauma had fractured the lamina, and where pressure had resulted. In these cases, laminectomy was advised, but it was suggested that, in many instances of this kind, the ordinary mechanical treatment proved of valuable service.

In disease of the knee, partial arthrectomy was advised, in preference to complete arthrectomy or to excision, especially in children. In the internal derangements of the knee, operative interference was advised, rather than the prolonged use of apparatus and fixation splints. In synovial disease, pure and simple, an occasional aspiration of the joint, with strapping, was regarded as good orthopedic surgery.

DISCUSSION.

Dr. L. A. SAYRE said that the paper covered too broad a field to admit of discussing it in detail, but in general the author had expressed his own views most accurately.

Dr. JOHN RIDLON did not consider that the element of time was very important, except in those exceptional cases where it was a difference between a few weeks and several years. On the principle of leverage, he had been able to reduce the deformity in some of the very worst cases of hip-joint disease in a few hours, or a few days, as safely by mechanical means as by operation. It was only the question between a few days following an operation, and a few days more with mechanical treatment, and, under these circumstances, we should not think of doing a cutting operation. In all cases of disease of the hip or of the knee, leverage reduction will accomplish the result as well as operation.

Dr. S. KETCH said that while theoretically the orthopedic surgeon should be a good general operating surgeon, in practice he is not frequently called upon to perform operations, and hence, could not be expected to be as skilful manually as surgeons who are constantly operating, and on this account, a natural division of labor was founded. He inferred from the paper that the author must have met with a class of cases in which it was unusually difficult to reduce the flexion, for, as a rule, there was no special difficulty about reducing this deformity, provided sufficient time were allowed. Forcible leverage or stretching adds an unnecessary risk, as there is no way of accurately gauging the amount of force employed, and hence, there is danger of inflicting traumatism which will result in lengthening the course of the disease, and causing a speedy return of the deformity.

Dr. W. R. TOWNSEND thought there was one class of cases in which mistakes are likely to follow mechanical treatment, but which yield brilliant results after operation, viz., the so-called periarticular abscesses. Such an abscess situated outside of the hip-joint often gives rise to symptoms simulating hip disease, and if not treated by operation, there is great danger of the abscess opening into the joint.

Dr. L. W. HUBBARD endorsed what Dr. Ketch had said about the treatment of deformity in the early stages, and he had found in his own experience, that the reduction was usually quite rapid. He had never seen a case of hip disease in any stage, where there was motion, in which the deformity could not be reduced by position and traction in a short time, usually not over six to eight weeks. He could not see the force of the remarks just made about periarticular abscesses, for they are just as likely to open externally as internally, and, as a rule, they heal quickly without operation.

Dr. H. W. BERG said that, had it not been for careful attention to mechanical details, such important orthopedic appliances as the plaster jacket, the long splint, and the Taylor brace, would not have been known, yet orthopedic surgery should be broad enough to include within its scope both mechanical and operative treatment.

Dr. N. M. SHAFFER thought that many of the conditions described

should necessarily come under the care of the general, and not the orthopedic, surgeon. We are all agreed, however, that the orthopedic surgeon should be competent to perform all the operations of general surgery, just as he should be able to diagnosticate typhoid fever, or the exanthemata, etc. But it did not follow because the orthopedist is prepared to perform these operations, or to diagnosticate the diseases coming under the care of the physician, that he should do either the one or the other, unless circumstances made it absolutely necessary for him to do so. Dr. Shaffer would have orthopedic surgeons devote themselves to the science and art of the mechanical treatment of deformities, using operative surgery as an adjunct to the mechanical work, rather than, as many of us are prone to do, make the mechanical part a sort of kite-tail to operative surgery. There is so much to be learned, and so much to be developed, in the continually broadening field of mechanical treatment, that there seems to be no excuse for the present tendency of orthopedic surgery to invade the well-recognized boundaries of general surgery. The tendency ought to be the other way, if orthopedic surgery is to succeed as a specialty.

Dr. R. H. Sayre said that orthopedic surgeons should be competent to take charge of a case from beginning to end, whether it required mechanical or operative treatment. Limiting orthopedic surgery to the use of apparatus is like limiting the oculist to the application of glasses for the correction of refractive errors.

Dr. Royal Whitman said that he was unable to see the force or the application of Dr. Shaffer's remarks on the paper of the evening. A specialist was so by reason of the class of cases he treated, not because of the means he employed. The broadening field for this specialty was the study of the etiology, development and cure of deformities; the study of the course, complications, and ultimate results of joint diseases. Treatment must vary with the social environment of the patient, the severity and duration of the disease or deformity, and the most successful surgeon was the one who could best adapt the means to the end to be accomplished.

Early diagnosis and efficient treatment would, to a great extent, obviate the necessity for operation, and it was proper for one who could select his cases, to devote himself exclusively to mechanical treatment. On the other hand, many chronic and desperate cases of disease and deformity were brought to the institution with which he was connected. These patients would be neglected at home, and rejected at general hospitals. Mechanical treatment alone in this class was ineffective, unless supplemented by operation, which was often a necessary and a life-saving procedure. This exaltation of mechanics was opposed to the best interests of the patients, since, in the minds of many, mechanical and operative treatment, which are mutually

dependent, were contrasted and opposed to one another : thus patients, on the one hand, were subjected to early and unnecessary operation, and afterwards neglected, and, on the other, the benefits of legitimate surgical interference were not appreciated. Why a broader and, as it seemed to him, more rational view of the subject need prevent the study and appreciation of mechanical supports, was not apparent. Believing that disease was to be treated in its entirety, and not in phases, he was unable to accept the limitations that Dr. Shaffer would impose on the future development of orthopedic surgery.

The CHAIRMAN said that if the orthopedic surgeon must be familiar with operative methods, as undoubtedly he must, he should also be a competent neurologist, for just as serious mistakes would follow ignorance of this subject as ignorance of operative surgery. Certain limitations are naturally placed upon one's practice, depending upon whether it is private, or dispensary, or hospital practice ; for, in the latter, it is often not the best ultimate result, but the best that can be obtained within a limited time, or with limited means, that must decide the plan of treatment to be adopted. The author's directions in regard to the reduction of the deformity in joint disease, and especially in certain stages of hip disease, while perhaps successful with him, would be exceedingly dangerous if followed by the general practitioner.

Dr. GIBNEY, in closing the discussion, said that the great drawback to letting the general surgeon operate upon our cases, is that we frequently lose sight of them, and they are accordingly allowed to go without the use of protective apparatus, and that careful treatment after operation, which is necessary in all these cases to insure good results.

NITRIC ACID IN MALIGNANT PUSTULE.—Dr. von Ruck reports (*N. C. Med. Jour.*) a case of malignant pustule upon the forefinger of the left hand, which came under his notice before general infection had occurred. The pustule presented the characteristics as described in medical literature ; the source of infection was, however, obscure. The patient had been handling cattle, and the day before its occurrence had cleaned out with his hands the mangers of his cattle barn. Microscopical examination of the discharging serum from the vesicle was negative, but upon consultation it was determined to destroy the vesicle and its base with fuming nitric acid, and to make culture experiments with the discharging serum. The culture, in a moist brood oven, with a temperature of 100° F., succeeded, and the diagnosis was confirmed by the characteristic growth of the anthrax bacillus. The patient made a prompt recovery.—*St. Louis Med. and Sur. Jour.*

Selections and Abstracts.

THE GYNECOLOGICAL WORK OF DR. JOSEPH PRICE.[1]

By GEO. F. FRENCH, A. M., M. D., Minneapolis.

Since our last meeting I have had the opportunity of observing some very remarkable surgical work and studying the methods of one of America's foremost surgeons.

Although still a young man, Dr. Joseph Price, of Philadelphia, holds a clinic for the world. While he eagerly scrutinizes and studies the work of all who have distinguished themselves in surgery, and is quick to perceive and praise excellence wherever found, his ideals are Tait and Emmet. He finds Tait's knowledge of abdominal and pelvic disease exact and positive, his skill and precision in this line of work wonderful, and says he would himself feel honored to be classed as a pupil of this model for surgeons, this teacher of teachers.

Following in the wake of Tait's teachings, Dr. Price began his work in alleys, cellars, and stable lofts, making 121 sections with but a single death, and this he ascribed to starvation. This success established his confidence in the principles expounded by Tait, and laid the foundation for his subsequent brilliant career. Skilful surgery, absolute cleanliness, irrigation, and a deftly placed drainage tube ought, he believes, to give very nearly a *nil* mortality.

Koeberle's extraperitoneal method for supra-vaginal hysterectomy in the treatment of uterine fibroids or myomata, gives, according to Dr. Price, the best results. He has had seventy-five consecutive supra-vaginal hysterectomies with four deaths, two of which were due to malignant disease; fifty vaginal hysterectomies for cancer with one death,—a record which, I am informed, has no parallel. Of abdominal sections for ectopic gestation, he has had sixty-six with two deaths, which with characteristic candor and modesty he ascribes to bad surgery; fifty-eight consecutive cases without a death. Of these, several appeared moribund when laid on the table. In some cases the operations were made precipitately, without preparation; in two, the nurses protested that the women were quite dead. In the whole series of 1,300 completed abdominal sections he has lost forty-six; the deaths have been largely in puerperal cases, appendicitis, bowel-obstruction and malignant disease. He

1. Remarks before the Minnesota Academy of Medicine, April 6, 1892.

thinks that six of the deaths were due to avoidable accidents, three to permitting his pupils to do tying, and not a few lives were lost through complications entailed by previous uncompleted operations. In one, five futile sections had been made prior to his own operation.

Dr. Price affirms that operations done in the morning exhibit a lower rate of mortality than those made in the afternoon. He improvises an operating room for each occasion, and thinks a general operating room objectionable.

I was greatly pleased to observe Dr. Price's admiration of Emmet. He said: "Tait is the master workman in all abdominal and pelvic surgery, but Emmet is my ideal surgeon in plastic work."—*Northwestern Lancet.*

As the history of the influenza bacillus nears completion, so does the evidence in favor of this germ forming a spore seem more certain. This fact will explain much that we have been at a loss to account for in the occurrence and spread of past influenza epidemics. Spores of other diseases will live for years in the ground or elsewhere, and develop at any time when the circumstances are favorable. Fifty cases of control experiments and further work in the cultivation and inoculation of the Pfeiffer bacillus gave corroborative results. The bacilli disappear from the blood and sputum in from five to fourteen days, excepting in cases of lung complication, where they remain for three weeks. In the epithelial erosions, the lymphatic channels, and in the visceral organs, the germs are present in vast numbers. Inoculations on the Schnideriian membrane of animals leads to fatal septic pneumonia. Thus we see that another substantiated discovery has been added to the achievements of bacteriological science.

Chemotaxis.— *The St. Louis Medical Review* seems to take exception to this new term, because it is not found in Foster's Dictionary. This seems a very poor apology for an excuse why the term should not be used, as all words originated outside of dictionaries. The term refers to the faculty possessed by all motile bacteria of moving toward and away from certain substances which seem to attract or repel them; it is the outcome of advanced bacteriological observations and a consequent demand for a term to explain a certain condition. This faculty of *chemotaxis* is, however, not confined to bacteria; it is manifest also in plasmodia, in myxo-

mycetes and in other unicellular organisms, hence the additional term, chemotropism, from the Greek — *Τροπος* — to turn.

Owing to its great practical importance, the time occupied in the absorption of catgut ligatures has been a subject very frequently discussed. The *process*, by softening and infiltration, then becoming imbedded in connective tissue and compressed, forming a granular detritis, undergoing liquefaction and subsequent absorption or removal by phagocytes or the wandering cells, has been understood since Flemming's substantiating investigations. The time occupied in this change which the catgut must undergo in absorption seems independent of the manner in which it is prepared, whether by VonBergmann's ether, sublimate, and alcohol method, by McEwen's chromic acid, or Lister's carbolic acid method, or by the Benkisser-Reverdin process of dehydration and deoleation, then disinfection by hot steam. These, together with Kocher's sterilization in juniper oil or Brunner's sterilization in xylol, seem *non-influential* in affecting the time which animal ligatures remain unabsorbed. Tillmanns, in his investigations, has found that up to the twenty-second day there is scarcely any change in catgut suture, and in four cases after nearly three months it remained unchanged.

Recent experiments by Hallwachs have shown that not until after six months does catgut inserted into *the bodies* of animals disappear entirely. *Repeatedly* this observation has been confirmed by operators, and not infrequently after *four weeks'* catgut, as silk, used in plastic vaginal operations, may still be seen.

There are cases on record, in which after over 1.2, 1½, or 2 *years*, catgut suture has been found in the uterus and in peritoneal cicatrices. The fear occasionally expressed that catgut ligature or suture may too rapidly disappear, therefore, seems illfounded. It persists much longer, many times, than is desired. F. J. T.

Bromide of Strontium in Gastric Troubles. — A great deal has recently been written in the French journals on the therapeutic value of strontium. Germain Sée has, noticing that in cases of Bright's disease digestive troubles were often very much benefited, tried the effect of bromide of strontium in different forms of gastric troubles in doses of from half a drachm a day. Different forms of dyspepsia were much benefited by its use. He suggests that the iodide of strontium may with advantage be substituted for the iodide of potassium in cases of heart disease.—*Doctors' Weekly.*

BUFFALO MEDICAL AND SURGICAL JOURNAL

A MONTHLY REVIEW OF MEDICINE AND SURGERY.

EDITORS:

THOMAS LOTHROP, M. D. - - W. WARREN POTTER, M. D.

All communications, whether of a literary or business character, should be addressed to the managing editor: 281 FRANKLIN STREET, BUFFALO, N. Y.

VOL. XXXI. JUNE, 1892. No. 11.

THE COLLEGE COMMENCEMENTS.

THE NIAGARA UNIVERSITY MEDICAL COLLEGE held its graduating exercises at the Star Theatre, on Monday evening, May 2d, where a large audience was assembled to witness the proceedings. The Rt. Rev. Bishop Ryan, Chancellor of the University, presided, and President Cronyn of the Faculty introduced the exercises in a few brief remarks. The degree of Doctor of Medicine was conferred, according to the English hooded rite, upon the following-named candidates: Frederick A. Hayes, Buffalo; Alois Jokl, Buffalo; James Edward Culbert, Scio; James Joseph McAvoy, Waterbury, Conn.; James Joseph Kane, Buffalo; Charles Strong Dickenson, Johnson's Creek; Joseph Henry Dunigan, Greenwood; James Martin Sweeney, New Orleans, La. The Rev. Wm. Burnett Wright delivered the address to the graduating class, which was received with enthusiasm. Then followed the banquet at The Genesee, which was served with much elaboration, and was an occasion of great interest. Dr. J. J. Twohey acted as toastmaster, who announced in their order the following speakers: Medical Department of Niagara University, Professor Thomas Lothrop; The Clergy, Rev. Andrew E. Purdy; The Legal Profession, D. J. Kenefick; Niagara University, Literary Department, Professor Grace; The Press, by Leslie Thom; Valedictory Address by Dr. J. J. McAvoy, of the graduate class.

The Alumni Association held its meeting at the college building during the day, at which time papers were read as follows: A Conservative View of the Treatment of Appendicitis, Illustrative Cases, by N. G. Richmond, M. D., Fredonia, N. Y.; Gallstones without Icterus, by C. B. LeVan, M. D., Buffalo, N. Y.; Influenza, with Microscopic Demonstrations of the Recently Discovered Bacillus, F. J. Thornbury, M. D., Buffalo, N. Y.

This brief synopsis does but imperfect justice to the ceremonies of this interesting occasion, which concluded one of the most satisfactory years in the history of this college.

The Medical College of Buffalo University held its forty-fifth annual commencement on Tuesday evening, May 3d, at Music Hall. The degree of Doctor of Medicine was conferred upon the following-named graduates:

Thomas P. C. Barnard, Walter Steele Barnes, Edward B. Belknap, William G. Bissell, Charles E. Boult, Clara E. Bowen, Arthur R. Bradbury, A. M., Warner C. Bush, N. Victoria Chappell, Alexander L. Ladd, Milton G. Lape, Ada C. Latham, Emma C. LeFevre, Barton T. McDowell, Albert H. Macbeth, James F. Macpherson, Marion E. Martin, Henry H. Mayne, William J. Chisholm, Ferdinand G. Moehlau, Amanda M. Congdon, Nellie Edmonds Murray, Mortimer S. Coon, Samuel R. Peacock, Andre M. Cowles, M. D., Howard A. Pease, Arland Lewis Darling, John C. Preston, Archie I. Drake, Benjamin W. Readshaw, Henry A. Eastman, Reuben A. Reeves, William Follett, Jr., Hudson M. Roberts, William C. Fritz, William Z. Roberts, Edward L. Frost, Lamont H. Ross, Maud Josephine Frye, Lister Gibbons, Morris S. Hadsall, George J. Hearne, Gustavus A. Hitzell, George S. Hobbie, Harry Corwin Jones, Wirt W. Jones, C. Oakley Sayres, Owen M. Shreve, Ph. B., Edward E. Stanbro, Ph. G., George B. Stocker, Andrew J. Volker, Charles F. Wixom, John V. Woodruff and Samuel W. Worrell.

The degree of Doctor of Pharmacy was conferred upon the following-named candidates:

Emery Jay Bargar, George Orrin Baxter, James Rollin Brown, Udell Sylvester Braman, Charles Wilton Chase, William Edward Delehant, Burt F. Disbrow, Margaret Elizabeth Fisher, Earl Look Hess, Max Lothar Kaesnter, William Arnold Kendall, James Bryden Mason, Adelbert Coon Miller, Rosa Belle Mosher, William Burt Reed, Edward James Rogers, Frank Rowley, Jr., John Timothy Sanford, Ernest Everett Vahey, Ernest Brice Walker, and Benjamin Howard Westgate.

The address to the graduating classes was delivered by Dr. George M. Gould, of Philadelphia, editor of the *Medical News*, and the address to the Alumni was made by Professor James Law, of Cornell University. After the exercises at Music Hall were concluded, the annual banquet of the Alumni was served at The Gene-

see. Dr. M. B. Folwell presided, and toasts were responded to by the Hon. E. C. Sprague, the Rev. Wm. S. Hubbell, Dr. Charles S. Butler, the Rev. Frank S. Fitch, Mr. George E. Vincent, and Dr. J. V. Woodruff.

The annual meeting of the Alumni was held at the college building during the day, and a large number of the graduates attended. Papers were read on Parasites by Dr. H. D. Walker; Clinical Instruction in Obstetrics, by Dr. P. W. Van Peyma; Hysteria in Children, by Dr. J. W. Putnam; and One Not Well-known Cause of Conjunctivitis, by Dr. Julius Pohlman.

At the meeting of the Council, held in the afternoon, arrangements were made for the organization of a department of dentistry, which will be ready for the reception of students in the Autumn. The instructors chosen are Drs. William C. Barrett, Alfred P. Southwick, Herbert A. Birdsall, and Frank E. Howard. This proved one of the most satisfactory gatherings of the Alumni, and one of the most interesting commencement occasions in the history of the college.

TOPICS OF THE MONTH.

The *American Lancet* informs the profession that arrangements for the approaching meeting of the American Medical Association are progressing satisfactorily. It asserts that everything that the Detroit profession can command will be placed at the service of the Association, and the united profession of Michigan cordially invites the attendance at the meeting of every member of the profession throughout the country. The *Lancet*, for itself, urges that every person interested shall come and remain during the entire meeting. We cordially thank the *Lancet* for its generosity, in not limiting its invitation merely to members of the Association, but in extending a cordial welcome to all physicians of standing throughout the length and breadth of the land. From our knowledge of the hospitality of Detroit and its citizens, we believe that much satisfaction and delight will follow an acceptance of its generous hospitality on this occasion.

The *National Medical Review* has lately come to our table, and is a handsome periodical, to be issued monthly at the subscription price of one dollar a year. Dr. Charles H. Stowell, of Washington, D. C., is the editor, and it may be expected, from his knowledge

and experience as an editor and publisher, that he will make the *Review* an established success. For a long time Washington has been without a medical periodical, which seems very strange in a city where learning, letters, and libraries are concentrated in a remarkable degree. Dr. Stowell prepares all the articles and paragraphs of his journal himself, selecting from all sources such topics as seem to merit publication, and then presents their substance in abstract. We bespeak a large measure of success for Dr. Stowell in his enterprise.

The address of Dr. George M. Gould at the graduating exercises of the Buffalo University Medical College was a manly plea for loyalty to legitimate medicine, and a terrible indictment against all forms, modes, and devices of quackery. We wish we had space to publish it in full, but can only give a few selected pearls from this choice string:

. . . . . .

Quackery may be likened to a poor artificial eye—everybody can see through it except the patient.

. . . . . .

To be explicit and detailed, let me counsel a few "don'ts."

1. Don't be in a hurry for success.

2. Don't consult or fraternize with quacks of any kind or degree.

3. Don't be afraid of speaking out your denunciation of quackery, regardless of the loss of a few possible patients and the charge of jealousy.

4. Don't support medical journals run in the interests of the advertisers, journals that are muzzled, that are conciliatory, or non-denunciatory of quackery.

5. Don't sign a single certificate so long as you live as regards special, proprietary, or secret preparations.

6. Don't write a medical article in which such preparations are praised, or even mentioned.

7. Don't accept commissions or presents from druggists, manufacturers, opticians, or surgical instrument dealers.

8. Don't let any professional allusion to yourself, your opinions, or your work, get into the lay newspapers. Don't be a sneak advertiser, a "newspaper doctor."

9. In your own righteous wrath against quacks outside of the profession, don't forget that there are many in the profession,

and that they are the most despicable,—true wolves in sheep's clothing. I would rather be the "Wizard King of Pain," and buy affidavits of impossible cures at twenty dollars each, than a respectable hypocrite indirectly or secretly hobnobbing with newspaper reporters and supplying them with data.

. . . . . .

Reflect, thirdly, that all the world over, every physician, whenever asked, gives his services to the poor without demand or without hope of compensation. Would not a lawyer, or a locksmith, think one crazy if it were proposed that he should give a large share of his time and service for nothing?

Carry the thought on. The entire tremendous labor, for the benefit of the community, of keeping up the enormous hospital work of all the world's cities, is borne by physicians without a cent of pay. Are there, for example, thousands of similar institutions where the poor, free of charge, can get legal counsel and help? Is there one such?

. . . . . .

The Buffalo General Hospital has lately issued its twenty-third annual report, being for the year 1891. It is an interesting pamphlet, giving a résumé of the work of the hospital for the year, and contains a report of the training-school for nurses.

The Arnot-Ogden Memorial Hospital, of Elmira, presents a neat and interesting report for the year 1891. The buildings, which are handsome modern structures, together with the hospital grounds, stand as a memorial of the Arnot and Ogden families, and this, in our opinion, is one of the most substantial, lasting, and philanthropic ways in which family names can be perpetuated. We wish that more of this same kind of philanthropic spirit might pervade the wealthy people of our country.

The annual report of the Board of Managers of the Buffalo Historical Society, for the year 1891, is a handsome brochure of sixty-six pages, that does credit to the officers and members of this established institution. A handsome photogravure of the monument and Brown's statue of Red Jacket, erected in Forest Lawn Cemetery by the Buffalo Historical Society, faces page sixteen of this report, and is an index of what can be done in the way of

organized efforts to perpetuate historic memories. We hope this interesting report will be extensively read by our citizens, and that a large increase of membership will come to the society during the present year.

Mrs. Jane C. Stormont, widow of the late Dr. David W. Stormont, of Topeka, Kansas, has erected the Stormont fund for the establishment and maintenance of a medical library in the City of Topeka. Mrs. Stormont has given $10,000 to this enterprise, one-half to be a permanent fund, and the remainder to be used in the purchase of books. The profession of medicine everywhere commends the spirit which has actuated this generous-hearted and noble type of American womanhood, and looks forward to the wholesome influence that her example will exert.

The question of literary theft has always been an nteresting as well as a disturbing one. The St. Louis *Medical and Surgical Journal*, in a late number, says that by a recent decision of a French Tribunal a medical journal is not permitted to publish an extract from another without giving due credit. We think that this decision might properly be applied to the administration of American law, and would have a beneficial influence on many medical journals in this country. The *Medical and Surgical Journal* cites a case where a guilty party was condemned to pay a large sum for every article cribbed, and to publish the findings of the court. If some such law were enacted here, its influence would be salutary.

A Famous Malpractice Case.—Most of our readers in this vicinity have been made aware, by the daily newspapers, of the fact that an action has lately been tried in the courts of Buffalo, entitled Kemball vs. Cary. The details of this action, which has been tried twice, the last time by a struck jury, and resulted in a verdict of no cause of action, are familiar to our readers. It is not, therefore, our purpose nor our duty to take up space in these columns with even a résumé of the case, but as observers of medical affairs in this city and vicinity we are interested in the prosperity and honor of the medical profession, and we wish to record our approval of the finding of the jury in the last trial of this now somewhat famous case. There cannot be two opinions among careful observers as to the justice of the verdict, and we congratulate Dr. Cary, the defendant,

upon the sterling and successful fight that he has made for himself, as well as for his professional brethren, in contesting this case. The lesson to be drawn is, that when a physician engages in a case with good intent, and gives his time and skilful attention to its management, he must not be mulcted in damages by reason of some technicality of law or through the machinations of designing men.

We have received a list of an extensive line of standard and pharmaceutical preparations, the modern medicaments manufactured by Parke, Davis & Co., of Detroit, which they have recently issued to send out to the profession. One of the notable features of this exceedingly attractive and well-arranged list is the representation by forty engravings of the laboratories at Detroit, and the branches at New York, Kansas City, and Wakeville, Ont., of this famous house. These engravings comprise views of the interior and exterior of the laboratories, offices, and sections of the department at Detroit, and altogether it appears the most complete list ever published of the products of this well-known house. It will be welcomed by every friend and patron everywhere, and will be sent to all physicians on application.

The sudden death of Sir Morell Mackenzie, which occurred at his home in London, February 3, 1892, has afforded occasion for many tender expressions of affectionate regard for this great leader from his American friends and admirers. Among them we select the following beautiful monody, from the pen of Dr. William Porter, of St. Louis, as a most touching tribute to the life and character of our deceased friend :

SIR MORELL MACKENZIE.

The master rests. After the day of toil
An urgent message came to him, and he
Well used to sudden calls, in quiet haste,
With kind good-night went out and all was still.
And now his work is done ; to him no more
Will come the suffering ones and those who need
The helping hand and words of goodly cheer.
His last response completed all his work.
O strong and gentle heart, ours is the loss
Who knew thee well—and knowing loved thee more.
Ours is the loss and thine the great reward.
We crown thee victor, O thou kingly dead.

We have heretofore (Volume XXIX., page 592, April, 1890,) called attention to the frequent mispronunciation of "gynecology." We return to the subject once more, because we have been unable to discover any considerable improvement in the pronunciation of this much abused word. In a paper upon Medical Orthoepy, by Dr. J. F. Oaks, of Chicago, we find the following:

"*Of the Consonants.*—The consonants in Latin, according to the English method, are usually pronounced like the corresponding English letters in the same situation; *e. g.*, C has the sound of s, and G the sound of j, before e, i, and y, and the diphthongs æ and œ. Since it is reasonably certain that C and G were always hard in the language of the ancient Romans and Greeks, some authors contend that we should assign to these letters in words of Greek or Latin origin the same hard sounds found in the original language. The premises are incorrect and inconsistent with general usage. We say ġeometry, ġenesis, and not ḡeometry, ḡenesis, and yet the latter is no more unreasonable than to say ḡў′necology. The orthography of the latter word in Latin is G.y.n.e.c.o.l.o.g.i.a., and is pronounced according to the Roman method, ḡўnecolo′-ḡia, and in conformity with the English method gў′n ′ecolo′ġia. We have, however, in the word gynecology the English analogue, conforming to English orthography, and is pronounced ġўn-ecol′ oġy, like ġўnarchy and ġўneocracy of similar analogy and etymology."

This would seem to settle the matter authoritatively on a question where there ought never to have been any difference of opinion, since there is but one right way to pronounce this word.

A comprehensive series of World's Congresses will be held at Chicago during the season of the Columbian Exposition of 1893, among which will occur the World's Congress of Pharmacists. This Pharmaceutical Congress will be under the supervision of a special committee, of which Oscar Oldberg is chairman, and a comprehensive sketch of the plans of the congress has been sent out to the public press and all interested in the success of pharmaceutical affairs. We need not say that this subject is one of vital interest to the profession of medicine, as well as to the patrons of pharmacy, and we are pleased to record our approbation of the comprehensive scheme which is outlined in the address of the committee, as well as to give it the encouragement of our kindly words and sanction.

THE bulletin of the Tennessee State Board of Health for January complimented the State of Michigan for its advanced standard and progressive excellence in regard to its public health affairs. The bulletin commends the action of the Michigan State Board of Health in holding frequent sanitary conventions in different parts of the State, and asks other States to use similar methods. There can be no doubt that the system which Michigan has inaugurated and carried on so successfully, is one that every State may do well to imitate, for it serves to educate the masses with reference to the importance of hygienic and sanitary measures.

THE *Medical Missionary Record*, for April, states that Mrs. Howard, of Buffalo, has given $2,000 to meet the cost of erecting a wing to the Westminster Hospital, Oroomiah, Persia. We wish the *Record* had stated Mrs. Howard's full name, that we might give her proper credit for this philanthropic act, and which, to quote the language of the *Record*, must be a pleasant satisfaction to herself, and a great blessing to the poor suffering women of Persia. It seems as though the women were outstripping everybody in the race for philanthropic work.

THE Students' Exemption Bill, which has created so much concern on the part of the friends of medical education reform, did not become a law after all. It passed the State Senate, and under the pressure of organized effort on the part of medical students, backed by very many members of the medical profession who ought to have been in better business, it came very near favorable action in the house. It is probable that the even vote in the Committee on Public Health, which practically killed the bill, was largely due to the influence of the Speaker of the Assembly, Dr. R. P. Bush, who attended the hearings, and who is well known for his friendliness to the State Examiners' law, as well as for his opposition to any measures that seek to render its effects nugatory. We are pleased to notice that the *Post-Graduate* gives Dr. Bush full credit for his manly action in this matter, as well as for his opposition to all medical laws that were offered in the late legislature, whose objects were to degrade legitimate medicine. In this connection it may not be improper for us to remark that the biographical sketch of Speaker Bush, that we published in the February number of this journal, has been extensively copied, either in whole or in part, by the medical journals

throughout the country, some of which have been generous enough to credit the JOURNAL with what it said.

THE abatement of nuisances seems to be in order, and we note that considerable progress is making by the municipal authorities in regard to this subject. We beg, therefore, to suggest that the church bell nuisance be not overlooked. This relic of a past age, when the people worshipped on high hills and in low valleys, ought not to be tolerated in a populous city where health and even life may hang upon a thread in the vicinage of the awful din that the conglomerate sounds of numerous bells create, especially if they are hung in one tower. It is in vain that appeals have been made to certain religious sects on the subject, and in more than one instance, do we know, where one of these sects has refused to stop the ringing of bells even when death was nigh at hand in their immediate vicinity. We hope the high hand of municipal authority will stretch itself out, and lay it down heavily on this nuisance that menaces comfort and sometimes even life.

THE next examinations of candidates for the license to practice medicine in this State, will be held on June 14th, 15th, 16th, and 17th, in the following-named cities: New York, 410 E. Twenty-sixth St.; Albany, at the High School; Syracuse, at the High School; Buffalo, at the High School. The examinations will be conducted as follows: Tuesday, June 14th, on Anatomy, Physiology, and Hygiene; Wednesday, June 15th, on Chemistry and Surgery; Thursday, June 16th, on Obstetrics, Pathology, and Diagnosis; Friday, June 17th, on Therapeutics.

Applications should be made to the State Board of Regents at once for permission to appear at these examinations.

THE Section on Medical Pedagogics of the Pan-American Medical Congress of 1893 will be one of the most important subdivisions of that great Congress. It will have to do with the methods of teaching medicine in all its various phases and aspects, and will deal with the question in a practical, and not theoretical, manner. This section will be presided over by Dr. D. B. St. John Roosa, of New York, than whom we know no more competent man to administer the important affairs of this very important section.

THE FRESH AIR MISSION of Buffalo has decided that if proper encouragement is given, it will this year add to its activities a hospital for the treatment of cholera infantum. In the JOURNAL for September, 1889, Vol. XXIX., page 123, we called attention to a hospital for a similar purpose, which is located at Charlotte, and which was organized and is maintained by the benevolent citizens of Rochester. We suggested the propriety of establishing a similar hospital in Buffalo. The fruits of our suggestion appear to have taken root, and a public meeting has been held, which was addressed by Dr. E. M. Moore and others, of Rochester, who were the projectors of the Charlotte Hospital. It is to be hoped that there will be no lack of spirit and interest in this subject, and that the funds necessary to maintain such a hospital will be forthcoming. It is one of the most noble charities that philanthropic people can establish.

THE Buffalo Academy of Medicine, the forming of which we brought to the notice of our readers in the April issue of the JOURNAL, was made an accomplished fact at a meeting of the associate societies, held at the Y. M. C. A. Building, Tuesday evening, May 17, 1892. After adopting the constitution and by-laws that had been carefully prepared by the representative committee, nominations of officers and other arrangements were made in preparation for the annual meeting, Tuesday, June 21, 1892, at which time the election will be held. It will be conducted on the Australian ballot system, and the following nominations have been made: For president—Dr. Thomas Lothrop, Dr. DeLancey Rochester, Dr. C. C. Wyckoff, Dr. John Cronyn, and Dr. C. G. Stockton. For trustees—Drs. F. W. Bartlett, J. W. Putnam, A. E. Persons, A. Dagenais, Benjamin Long, Roswell Park. For secretary—Dr. W. C. Krauss. For treasurer—Drs. Eugene A. Smith, H. E. Hayd.

Personal.

DR. J. B. ANDREWS, Superintendent of the Buffalo State Hospital, was elected president of the Association of Medical Superintendents of American Institutions for the Insane at its recent meeting in Washington.

DR. GILBERT I. CULLEN, editor of the Cincinnati *Medical Journal*, was elected Treasurer of the Ohio State Medical Society, at its recent meeting in Cincinnati.

Dr. M. D. Mann, Professor of Obstetrics and Gynecology in the Buffalo University Medical College, sailed for Europe on the 25th of May, to spend some weeks in Wales and England, expecting to return about the 10th of July. His trip is simply for recreation and rest.

Obituary.

Dr. James Ross, one of the most prominent physicians of Toronto, died at his home in that city, April 2, 1892, aged sixty years. Dr. Ross had a large clientele, and was especially prominent in the practice of obstetrics and diseases of children. During an active professional life of forty years he attended 6,787 cases of labor,—a remarkable number for one man to see in private practice. The deceased leaves a distinguished son, Dr. James F. W. Ross, who has already made a name for himself in the field of abdominal surgery. We offer our sympathies to the surviving members of this bereaved family.

Mr. Orsamus G. Warren, senior proprietor of the *Buffalo Commercial*, died at his residence in this city Friday, May 6, 1892, of pneumonia, aged forty-six years. Mr. Warren had been connected with the press since boyhood, and grew up under the masterful tutelage of his father, the late James D. Warren, whose name and fame were known throughout the land. Orsamus G. was his eldest son, and assumed the proprietorship of the *Commercial* at the death of his father, whose partnership he had enjoyed for many years. Mr. Warren was a strong personality, enumerating his friends by hundreds and thousands, and will be sadly missed in political, business, and newspaper circles.

Appropriate action, expressing sympathy for his family and appreciation of his worth, has been taken by the Merchants' Exchange, Buffalo Press Club, Republican League, American Exchange Bank, and several other business and social interests with which Mr. Warren was identified; while telegrams of condolence and editorials of sympathy have poured in from all quarters. Seldom has a citizen of Buffalo received such an avalanche of memorial tributes, and his sudden taking off will continue to be regretted by thousands of his fellow-citizens.

Society Meetings.

The eleventh International Medical Congress will be held in Rome, Italy, in September, 1893.

The Mississippi Valley Medical Association will hold its eighteenth annual session at Cincinnati, Ohio, Wednesday, Thursday, and Friday, October 12, 13, and 14, 1892. A large attendance and a valuable programme are expected. President, Chas. A. L. Reed, Cincinnati; secretary, E. S. McKee, Cincinnati.

The American Academy of Medicine will hold its seventeenth annual meeting at the Cadillac Hotel, Detroit, on Saturday, June 4th, and Monday, June 6, 1892, under the presidency of Dr. P. S. Connor, of Cincinnati. A number of papers will be read, and interesting discussions are promised.

The American Pharmaceutical Association will hold its fortieth annual meeting at the Profile House, White Mountain, N. H., commencing Thursday, July 14, 1892, at nine o'clock, A. M. An elaborate programme has been prepared, including visits and drives to the various points of interest in the vicinity of the meeting. The local secretary is H. M. Whitney, Lawrence, Mass., who should be addressed on all subjects pertaining to the meeting.

The Medical Society of the State of New York.—*Official Bulletin.*—The business committee of this society has been organized for the meeting of February, 1893, by the appointment of Dr. Seneca D. Powell, of No. 12 West Fortieth street, New York City, Chairman, and Drs. William Maddren, of Brooklyn, and John O. Roe, of Rochester, associates. The programme for the scientific work of the session is already well advanced in its preparation.

The American Electro-Therapeutic Association will hold its second annual meeting at the Academy of Medicine in New York City, October 4, 5, and 6, 1892, under the presidency of Dr. W. J. Morton. Dr. H. R. Bigelow is the Secretary.

The American Association of Obstetricians and Gynecologists will hold its fifth annual meeting at the Lindell Hotel, in St. Louis, on Tuesday, Wednesday, and Thursday, September 20, 21, 22, 1892, under the presidency of Dr. A. Vander Veer, of Albany.

The Medical Society of the County of Erie will hold its semi-annual meeting at the Y. M. C. A. Building, Mohawk, Pearl, and Genesee streets, on Tuesday, June 14, 1892, beginning at ten o'clock, A. M. Dr. Joseph Price, of Philadelphia, will read a paper entitled The Natural History of Pelvic Inflammation; Dr. Lewis S. McMurtry, of Louisville, Ky., will read a paper entitled The Relation of So-called Minor Gynecological Operations to Pelvic Disease; Dr. Charles A. L. Reed, of Cincinnati, will read a paper on Methods of Early Diagnosis of Intra-Pelvic Disease; and Dr. James F. W. Ross, of Toronto, will read a paper entitled Actual, Not Text-Book, Experience with Cases of Ectopic Gestation. Other papers have been promised, and a cordial invitation is extended to all physicians to attend the meeting.

Book Reviews.

A Manual of Operative Surgery. By Frederick Treves, F. R. C. S., Surgeon to and Lecturer on Anatomy at the London Hospital; Member of the Board of Examiners of the Royal College of Surgeons. In two octavo volumes, containing 1,550 pages, with 442 illustrations, mostly original. Per set, cloth, $9.00; leather, $11.00. Philadelphia: Lea Brothers & Co. 1892.

The literature of surgery is being constantly enriched by additions that come with frequent—we had almost said amazing—rapidity. This may be regarded as somewhat of a necessity, for the lines of surgical teaching as well as surgical practice have been almost entirely recast within the last ten or fifteen years. The present work, as the author states in his preface, concerns itself solely with the practical aspect of treatment by operation, with the technical details of operative surgery, and with such part of the surgeon's work as comes within the limits of an handicraft. Mr. Treves has long been known as one of the most progressive English surgeons, and he has been quoted with as much frequency of late as any of the British or Continental operators. He has shown a special aptitude for technique, and has demonstrated his capabilities as a teacher and as a contributor to the periodical literature of surgery. It would seem to be very proper, therefore, that this author, who is yet in his prime so far as years, physical and mental powers are concerned, to tell us something of what he himself has learned, the methods of applying his knowledge, and the results that may be confidently expected from an intelligent application thereof.

The first volume of Treves's manual discusses the following general divisions of the subject: First, General Principles; second, Anesthetics; third, Operations upon Arteries and Nerves; fourth, Amputations; fifth, Excisions; sixth, Operations upon Bones, Joints, and Tendons. Under the first division the student and practitioner alike, will find grouped many important subjects with which they should familiarize themselves before undertaking the responsibility of operative surgery. The second subdivision, wherein the administration of anesthetics is discussed, is not second in importance to any other surgical question. We maintain that no man is competent to set himself up as an operator, unless he is thoroughly familiar with all the various phases relating to the administration of anesthetics. He must serve an apprenticeship at this before he can turn his attention to the knife. To administer an anesthetic properly, safely, and adequately, is an accomplishment which, we regret to say, only a few are willing to undertake, and a still fewer number possess.

In Treves's book will be found some excellent suggestions that deserve to be carefully studied. In regard to the selection of an anesthetic, we have always held that in suitable cases chloroform might be given, and in other suitable cases ether, but in no case is it wise to administer what is known as the A. C. E. mixture, but we find in Treves's book the following, which presents itself to us with much force:

The selection of the anesthetic should be regulated by: (1) Condition of the patient: (2) the nature and the length of the operation about performed.

In every case the chloroformist should carefully observe the kind of patient entrusted to his care; he should notice how respiration is performed, more especially whether nasal respiration is present or not, and he should invariably feel the pulse before commencing his duties. With nitrous oxide, a stethoscopic examination of the chest is necessary, unless it is obvious from an inspection of the patient, or from other indications, that some intra-thoracic affection exists. With other anesthetics, it is usually a good plan to listen to the chest; but no prolonged stethoscopic examination need be resorted to unless special indications exist.

Generally speaking, nitrous oxide is the best anesthetic for very brief operations, and ether for long cases. As already mentioned, the disadvantages connected with the latter anesthetic may, to a great extent, be removed by preceding the inhalation by nitrous oxide or the A. C. E. mixture. There are, of course, many cases in which neither

nitrous oxide nor ether could be given. The following table has been drawn up to show these exceptions :

CASES SUITABLE FOR THE A. C. E. MIXTURE.	CASES SUITABLE FOR CHLOROFORM.
Infants and very young children.	Prolonged nasal or oral operations, and those with the actual cautery.
Most patients above sixty or sixty-five years of age.	Cases in which neither ether nor the A. C. E. mixture is well borne.
Extreme obesity, especially if associated with plethora.	Labor.
Most cases of advanced cardiac disease.	Marked atheroma.
Affections of the air passages or pleura, attended by dyspnea or cyanosis.	

After giving in detail the methods of administration of the anesthetic, and citing the chief difficulties and dangers connected with the anesthetic state, which are unusually valuable and explicit, the author passes on to Part III., in which he considers the ligature of arteries. The anatomical relations of the arteries are very clearly considered, and amply illustrated by clear and understandable cuts. Next comes Part IV., in which operations upon the nerves are described. A large portion of Volume I. is taken up with a minute description of the various amputations. This has heretofore been considered the brilliant part of surgical treatises, and it loses none of its interest in the hands of Treves, but, in the present era, bone surgery is receiving more attention than ever, and nowhere will be found more ample treatment of the subject than in the present work.

Volume II. opens with plastic surgery, which is considered in an exhaustive manner, and numerous illustrations are introduced to explain the text. Treves is particularly able in his consideration of plastic operations upon the bladder and urethra. Part IX. of the treatise is devoted to operations upon the neck, which are always full of interest to the general surgeon. Perhaps nowhere is our author more interesting than in the section which he devotes to operations upon the abdomen. He has had a large personal experience in this department of surgery, and speaks with the knowledge of a master. His description of all operations pertaining to intestinal surgery are especially pointed, as well as his detailed account of operations upon the kidney. We have not aimed, in this cursory review, to analyze in detail all the various improve-

ments noted in the several departments of this treatise, for it would seem unnecessary to do so, in view of the vast amount of literature which has accumulated in the various periodicals and through the Transactions of the special societies, but it has rather been our aim to point out some of the excellencies of this work of Treves, and we hesitate not to declare it to be one of the best manuals of operative surgery for the general practitioner to adopt as a guide.

In addition to the divisions of the subject that we have mentioned, the subject is further continued by dealing with surgical diseases of the rectum, head, spine, and thorax, which latter concludes the volume. A very complete index of subjects and authors is added, which makes the work one of easy reference. All through the volume, sub-heads, in display type, bring the various subjects readily before the eye of the reader, while the type and press-work are clear, and the paper of excellent quality and color. It is one of the handsomest surgical treatises that has appeared from the press in a long time.

TREATISE ON GYNECOLOGY, MEDICAL AND SURGICAL. By S. POZZI, M. D., Professor Agrégé á la Faculté de Médecine; Chirurgien de l'Hôpital Lourcine-Pascal, Paris; Honorary Fellow of the American Gynecological Society. Translated from the French edition under the supervision of, and with additions by, BROOKS H. WELLS, M. D., Lecturer on Gynecology at the New York Polyclinic; Fellow of the New York Obstetrical Society, and the New York Academy of Medicine. Volume II. With 174 wood engravings, and nine full-page plates in color. New York: William Wood & Co. 1892.

The second volume of this admirable treatise is now before us, and we proceed to name some of the special points of its excellence, though we find very little occasion to change our opinion of the general scope and value of the work, which we indicated in our notice of Volume I., in the May issue of the JOURNAL.

Beginning with Inflammation of the Uterine Adnexa, Pozzi first gives the classification, in Chapter 1, of Tubal Inflammations. He next takes up Non-Cystic Salpingitis, which includes the various conditions arising from infections, such as pertain to gonorrhea, parturition, and catarrhal disease. In the next chapter we find Pyosalpinx, Hydrosalpinx, and Hematosalpinx described under the general term of Cystic Oöphoro-Salpingitis. A handsome colored plate is introduced, illustrating a variety of Hematosalpinx simulating Tubal Pregnancy, which was furnished by Dr. Joseph Price. Also one from the same author, illustrating Pyosalpinx and

Ovarian Abscess with Universal Adhesions. These assist very much in the elaboration of this interesting subject, and are a decided addition to the volume. The pathology of pelvic abscess, so-called, is one of the most interesting of all the questions pertaining to pelvic surgery, and much light has lately been thrown upon the subject by a few American operators, who are constantly giving to periodical literature the benefits of their experiences. The editor has shown his appreciation of their work by introducing illustrations of it into this book, and the wisdom of such a course will be appreciated by all who have to deal with these important questions.

Under the title Extra-Uterine Pregnancy will be found some of the opinions of the author which have been developed through recent experience. We need not here enlarge upon this subject, for it has already become one of settled opinion with reference to many points, and in the main our author does not differ essentially from the most modern judgment on the subject. Plastic Surgery of the Genital Tract is considered at length in this volume, as well as Malformations of the Vagina and Uterus, together with Disorders of the Urinary Tract, and Diseases of the Rectum and Pelvis, which latter subject concludes the volume. An index of both volumes is added, which helps to make easy of reference, one of the most interesting and useful treatises upon gynecology which the decade has produced. The perfect press-work and binding are precisely like the first volume, and the two books make a handsome show upon the library shelves.

THE INTERNATIONAL MEDICAL ANNUAL AND PRACTITIONER'S INDEX FOR 1892. Edited by P. W. WILLIAMS, M. D., Secretary of Staff, assisted by a corps of thirty-two collaborators, European and American, specialists in their several departments. Six hundred and forty-four octavo pages. Illustrated. $2.75. E. B. Treat, publisher, 5 Cooper Union, New York.

This decidedly popular and valuable reference book is now before the public, and certainly the tenth issue is much superior to any of its predecessors. The corps of department editors have spared no pains in bringing their special fields up to the latest period before going to press, thus informing the busy practitioner of the most recent advances in our science.

The Annual is divided into three parts. Part I. treats of New Remedies, and New Applications of Old Remedies. Such agents as spermine, strontium, cactus, etc., are fully described, together with their therapeutic indications. Part II. comprises the major

portion of the book, and is given to the consideration of New Treatment. Part III. contains short papers by well-known writers on subjects of great importance to medical men. Those on The Recent Advances in Bacteriology, Medical Photography, Sanitary Science, and Use of Suppositories, show the range of subjects. The appendix contains a list of the medical works published during the year; also an incomplete list of new instruments, and a list of medical publishers. The illustrations, especially those in colors, as the endoscopic appearances of the bladder, etc., are handsomely executed, and add to the beauty of the Annual. Although everything is arranged in alphabetical order, a complete index is added, making it possible to seek any desired information with the greatest saving of time.

On the whole, the Annual is a very practical and handy book to possess, while, at the same time, the cost is trifling. W. C. K.

THE MUTTER LECTURES ON SURGICAL PATHOLOGY. Delivered before the College of Physicians of Philadelphia, 1890-91, by ROSWELL PARK, A. M., M. D., Professor of Surgery, Medical Department, University of Buffalo; Surgeon to the Buffalo General Hospital; Fellow of the German Congress of Surgeons, etc. Reprinted from the *Annals of Surgery*. Volumes XIII., XIV., and XV. Pp. viii. — 293. St. Louis: J. H. Chambers & Co. 1892.

To Professor Park's many friends in Buffalo and elsewhere, who have had occasion to listen to but fragments of his course of lectures on Surgical Pathology, it will be welcome news to know that they have been republished in book form. The synopsis of these lectures have been published in the columns of this journal, and, from time to time, excerpts from some of the lectures, so that our readers are not altogether unfamiliar with the scope and general bearing of the various subjects treated. The excellent work done by the author in surgical pathology and bacteriology enables him not only to re-investigate and confirm the work done by others, but also to add light and knowledge on subjects heretofore illy understood. The chapters on Wound Infection and Suppuration, The Results of the Absorption of the Products of Wound Infection, and those on Mixed and Secondary Infection, deserve special mention for their originality and completeness. The chapter on Tetany and Tetanus is interesting from a neuro-surgical point of view, and is replete with the latest information on these subjects. On the whole, Prof. Park's work is a worthy companion to the many treatises which have lately appeared on surgical pathology and bacteriology. W. C. K.

CONSUMPTION: HOW TO PREVENT IT AND HOW TO LIVE WITH IT. Its Nature, its Causes, its Prevention, and the Mode of Life, Climate, Exercise, Food, and Clothing, necessary for its Cure. By N. S. DAVIS, Jr., A. M., M. D., Professor of the Principles and Practice of Medicine, Chicago Medical College; Physician to Mercy Hospital; Member of the American Medical Association, Illinois State Medical Society, Chicago Medical Society, Chicago Academy of Sciences, Illinois State Microscopical Society; Fellow of the American Academy of Medicine; author of a hand-book on Diseases of the Lungs, Heart, and Kidneys. Philadelphia and London: F. A. Davis, publisher. 1891.

The title of this book is somewhat striking, and we confess that we do not understand its full import. It would be a boon to humanity if it could be taught how to prevent the disease in question so that it might not slay its hundred thousand annually in the United States. If Dr. Davis will tell the profession something that it does not already understand about this baneful malady, he will confer a lasting favor upon the human race. We discover in this book the usual rules for hygienic management, and some careful and considerate remarks with reference to the influence of properly selected climate. We think the best part of the book is contained in Chapter III., where some concise and well-considered rules are given, looking to the prevention of the disease, assuming that it is an infectious malady. The author has told much in this chapter that will serve to limit its ravages, if the rules that he lays down are adhered to. We commend the book to all who would read an agreeably written little volume on a subject of great concern to humanity.

SAUNDERS' POCKET MEDICAL FORMULARY. With an Appendix, containing Posological Table, Formulæ and Doses for Hypodermic Medication; Poisons and their Antidotes; Diameters of the Female Pelvis and Fetal Head; Diet List for Various Diseases; Obstetrical Table; Materials and Drugs used in Antiseptic Surgery, etc. By WILLIAM M. POWELL, M. D., author of Essentials of Diseases of Children; one of the Associate Editors of the Annual of the Universal Medical Sciences; Attending Physician to the Children's Seashore House for Invalid Children, and the Mercer House for Invalid Women, at Atlantic City, N. J.; Member of the Philadelphia Pathological Society. Formerly Instructor of Physical Diagnosis in University of Pennsylvania; Attending Physician to the Children's Clinic at the University of St. Clement's Hospital; Chief of the Medical Clinic of the Philadelphia Polyclinic. Philadelphia: W. B. Saunders, 913 Walnut street. 1891.

Whoever desires to have a ready-made prescription book will find one of the best in this little work. We are not of those who believe that ready-made formulæ are of much value, or that they

possess much merit in the literature of medicine, but as there is a demand for this kind of therapeutics, we are glad to have it done in good form and with some attention to accuracy. The authors quoted from for the most part are reliable, and this book, as we have remarked, fills the place that it has marked out for itself as well as or even better than some that have attempted to cover this field.

ESSENTIALS OF PHYSICS, arranged in the form of questions and answers. Prepared especially for Students of Medicine. By FRED J. BROCKWAY, M. D., Assistant Demonstrator of Anatomy at the College of Physicians and Surgeons, New York. With 155 illustrations. Philadelphia: W. B. Saunders, 913 Walnut street. 1892.

This is one of the most valuable books in the Saunders' Question Series. There are many reasons why medical students cannot devote as much time to the study of physics as they should, hence, it is well to have this subject condensed as much as possible. Dr. Brockway has accomplished this feat in the book before us without doing violence to its importance or otherwise belittling the subject. We advise every medical student who feels himself deficient in the study of physics to possess this valuable volume.

LEHRBUCH DER HEBAMMENKUNST. Von DR. BERNHARD SIGMUND SCHULTZE, Geheim Hofrath, Öff. Ord.; Prof. der Geburtshülfe; Director der Entbindungsanstalt und der Hebammenschule zu Jana; Mitglied der Medical Commission des Grossherzogth. Sachsen. Leipzig: Verlag von Wilhelm Engelmann. 1891. Pp. 380. Zehnte Auflage.

The ninth edition of this work was reviewed in the April (1890) number of the JOURNAL, p. 588. In speaking of the ninth edition, we ventured the assertion that it "would be as enthusiastically received as the former editions." Scarcely eighteen months had elapsed, and the edition was exhausted, necessitating the publishing of a tenth edition. This fact speaks of its popularity and value more than a reviewer's pen can hope to do, and consequently it is laid one side. No changes whatever have been made in this edition.

W. C. K.

LESSONS IN THE DIAGNOSIS AND TREATMENT OF EYE DISEASES. By CASEY A. WOOD, M. D. Physicians' Leisure Library. Price, cloth, 50 cents; paper, 25 cents. Detroit: Geo. S. Davis. 1891.

The author of this little manual states in the preface that it is intended "to aid the physician to detect and treat those diseases of the eye which experience has shown are most frequently over-

looked in the course of general practice." Yet the subjects touched upon in the various chapters include nearly every affection of the eye, besides various operations, some of which are far too technical for the general practitioner. The style of the book is clear, and the arrangement of the matter good. E. S.

Deafness and Discharges from the Ear. The Modern Treatment for the Radical Cure of Deafness, Otorrhea, Noises in the Head, Vertigo, and Distress in the Ear. By Samuel Sexton, M. D., Author of The Ear and its Diseases, etc., assisted by Alexander Duam, M. D. Small octavo, pp. 89. New York: J. H. Vail & Co. 1890.

In this handsome little volume of eighty-nine pages, the author has compressed much information on a subject of great importance to the general practitioner. Even the busy physician must always be prepared to give his patient intelligent advice upon the first symptoms that relate to deafness, and be able to treat the initial stages of the malady with skill and intelligence. Here will be found some of the best thoughts on this important subject, and they can easily be availed of by the masses, for the work is simple and reasonable in price.

A Dictionary of Treatment, or Therapeutic Index, including Medical and Surgical Therapeutics. By William Whitla, M. D., Professor of Materia Medica and Therapeutics in Queen's College, Belfast. Revised and adapted to the Pharmacopeia of the United States. In one octavo volume of 917 pages. Cloth, $4.00. Philadelphia: Lea Brothers & Co. 1892.

Of late, many books have been issued that are specially adapted to ready reference by the busy physician, some of which have been works of value, while others are only of indifferent worth. This book of Whitla belongs to the better class, and will be found one of the most satisfactory of its kind. It is not a work that can be given an analysis in these pages, but we commend it to the profession as one of the foremost reference books that have lately been put forth.

Cancer and its Treatment. By Daniel Lewis, A. M., M. D., Ph. D., Surgeon to the New York Skin and Cancer Hospital; Professor of Surgery (Cancerous Diseases) in the New York Post-Graduate Medical School. The Physicians' Leisure Library. Price, cloth, 50 cents; paper, 25 cents. Detroit, Mich.: Geo. S. Davis. 1892.

The author of this book has had a large experience in the treatment of the disease in question, and we may, therefore, expect out of his hands a most interesting and useful book. The practical

criticism to offer in regard to this treatise is that many of the subdivisions are too much condensed to be entirely satisfactory. Nevertheless, this could not well be otherwise in a book which must come within the limits required for a part of the Physicians' Leisure Library, and so this is not altogether the fault of the author. We hope that he will find occasion to elaborate the subject into a more complete treatise in the near future; meanwhile we commend this little volume to the careful examination of the profession. A few illustrations, two in color, add much to its interest.

BOOKS RECEIVED.

A System of Gynecology, with 359 illustrations; based upon a translation from the French of Samuel Pozzi. Revised by Curtis M. Beebe, M. D., Chicago, Ill. New York: J. B. Flint & Co.

Report of the Commissioner of Education for the year 1888-89. Volume I. Containing: Part I., Chapters I. to X.—A General and Comparative Exhibit of Education in the United States and Foreign Countries. Part II., Chapters XI. to XXI.—Normal Schools, Manual Training, Courses of Study, etc. Washington: Government Printing Office. 1891.

Report of the Commissioner of Education for the year 1888-89. Volume II. Containing: Part III., Chapters XXII. to XXXV.—Detailed Statistics of Educational Systems and Institutions, with Comments and Discussions. Washington: Government Printing Office. 1891.

Transactions of the Medical Society of the State of North Carolina. Thirty-eighth annual session, held at Asheville, N. C., May 26, 27, and 28, 1891. Wilmington, N. C.: Jackson & Bell. 1892.

The Fourth International Prison Congress, St. Petersburg, Russia. By C. D. Randall, Official Delegate from the United States Bureau of Education. Circular of Information, No. 2, 1891. Washington, D. C.: Government Printing Office. 1891.

The Science and Art of Midwifery. By William Thompson Lusk, A. M., M. D., Professor of Obstetrics and Diseases of Women and Children in the Bellevue Hospital Medical College; Consulting Physician to the Maternity Hospital and to the Foundling Asylum; Visiting Physician to the Emergency Hospital; Gynecologist to the Bellevue and to the St. Vincent Hospitals; Honorary Fellow of the Edinburgh and London Obstetrical Societies; Corresponding Fellow of the Obstetrical Societies of Paris and Leipzig; Corresponding Fellow of the Paris Academy of Medicine, etc. New edition. Revised and enlarged, with numerous illustrations. New York: D. Appleton & Co. 1892.

Outlines of Zoology. By J. Arthur Thomson, M. A., F. R. S. E., Lecturer on Zoology in the School of Medicine, Edinbugh; joint-author of the Evolution of Sex; author of the Study of Animal Life. With thirty-two full-page illustrations. New York: D. Appleton & Co. 1892

Diseases of the Eye. A Hand-Book of Ophthalmic Practice for Students and Practitioners. By G. E. de Schweinitz, M. D., Professor

of Diseases of the Eye in the Philadelphia Polyclinic; Lecturer on Medical Ophthalmoscopy in the University of Pennsylvania; Ophthalmic Surgeon to the Philadelphia Hospital, and to the Children's Hospital; Ophthalmologist to the Orthopedic Hospital and Infirmary for Nervous Diseases. With 216 illustrations and two chromo-lithograph plates. Philadelphia: W. B. Saunders, 913 Walnut street. 1892.

The Uses of Water in Modern Medicine. By Simon Baruch, M. D., Attending Physician to the Manhattan General Hospital and New York Juvenile Asylum; Consulting Physician to the Montefiore Home for Chronic Invalids; formerly Chairman of the Board of Health of South Carolina, etc., etc. Volume I. Detroit, Mich.: George S. Davis. 1892.

Diseases of the Nervous System. By J. A. Ormerod, M. D., Oxon., F. R. C. P., Lond., Medical Registrar and Demonstrator of Morbid Anatomy at St. Bartholomew's Hospital; Physician to the National Hospital for the Paralyzed and Epileptic, Queen Square, and to the City of London Hospital for Diseases of the Chest, Victoria Park. With numerous illustrations. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut street. 1892.

Treatise on the Diseases of Women, for the use of students and practitioners. By Alexander J. C. Skene, M. D., Professor of Gynecology in the Long Island College Hospital, Brooklyn, N. Y.; formerly Professor of Gynecology in the New York Post-Graduate Medical School; Gynecologist to the Long Island College Hospital; President of the American Gynecological Society, 1887; Corresponding Member of the British, Boston, and Detroit Gynecological Societies, of the Royal Society of the Medical and Natural Societies of Brussels, and of the Leipzig Obstetrical Society; Fellow of the New York Academy of Medicine; Ex-President of the Medical Society of the County of Kings. Ex-President of the New York Obstetrical Society. Second edition, revised and enlarged, with 251 engravings and nine chromo-lithographs. New York: D. Appleton & Co. 1892.

Encyclopedia of Medicine and Surgery. By various writers, enlarged, upon a new system, which embodies the methods of treatment employed by eminent practitioners of medicine. Compiled under the direction of the publishers, and including the writings of Drs. John Abercrombie, E. C. Beale, C. E. Beevor, Sidney Coupland, Frederick F. Eve, G. P. Field, J. K. Fowler, Wm. Gay, W. B. Hayden, G. E. Hermance, Victor Horsley, Henry Juler, C. B. Keetley, and others. New York: J. B. Flint & Co. 1892.

Pye's Surgical Handicraft: A Manual of Surgical Manipulations, Minor Surgery, and other matters connected with the work of house-surgeons and surgical dressers. With 300 illustrations on wood. First American, from the third London, edition. Revised and edited by T. H. R. Crawle, F. R. C. S., Surgical Registrar to St. Mary's Hospital; and Surgical Tutor and Joint Lecturer on Practical Surgery in the Medical School. Complete in one volume. New York: E. B. Treat, 5 Cooper Union. 1892.

Diseases of the Nervous System. By Jerome K. Bauduy, M. D., LL.D., Professor of the Diseases of the Mind and Nervous System, and of Medical Jurisprudence, Missouri Medical College, St. Louis; late Physician-in-Chief to St. Vincent's Institution for the Insane; Corresponding Member of the New York Society of Neurology and Electrology; formerly Consulting Physician of the St. Louis County Lunatic

Asylum ; Member of the New York Medico-Legal Society, etc. Second edition. Philadelphia : J. B. Lippincott Co. 1892.

The Electro-Therapeutics of Gynecology. By Austin H. Goelet, M. D., Fellow of the New York Academy of Medicine and of the New York Obstetrical Society ; Vice-President of the American Electro-Therapeutic Association ; Member of the Société Francaise d'Electro-therapie ; editor of the *Archives of Gynecology, Obstetrics, and Pediatrics*. Vols. I. and II. With illustrations. Physicians' Leisure Library. George S. Davis, Detroit, Mich. 1892.

Text-Book of the Eruptive and Continued Fevers. By John William Moore, B. A., M. D., M. Ch., Univ. Dubl.; Fellow and Registrar of the Royal College of Physicians of Ireland ; Physician to the Meath Hospital, Dublin ; Joint Professor of Practice of Medicine in the Schools of Surgery of the Royal College of Surgeons of Ireland ; Consulting Physician to Cork-street Fever Hospital, Dublin, and to the Whitworth Hospital, Drumcondra ; Ex-Scholar and Diplomat in State Medicine of Trinity College, Dublin. William Wood & Co., medical publishers, New York. 1892.

Eleventh Annual Report of the State Board of Health of Illinois, being for the year ended December 31, 1888. With an appendix, containing the Official Register of Physicians and Midwives, 1892. Springfield, Ill.: H. W. Rokker, State Printer and Binder. 1892.

Miscellany.

Messrs. D. Appleton & Co. announce the following in press : A Treatise on Diseases of the Rectum, Anus, and Sigmoid Flexure, by Joseph M. Mathews, M. D., of Louisville, Ky., Professor of the Principles and Practice of Surgery, and Clinical Lecturer on Diseases of the Rectum, in the Kentucky School of Medicine, etc. The work will be illustrated by six chromo-lithographs, showing operations on fistula, hemorrhoids, and other affections of the rectum, and by numerous cuts in the text. Dr. Mathews has devoted many years to the study and teaching of the diseases which are the subject of the treatise, and has written a work that is unique in its excellence and fully up to date. His prominence in the medical profession as a surgeon, teacher, and specialist, insures the success of the work. It is expected that the book will be ready during the present month.

Messrs. P. Blakiston, Son & Co. announce the following important new text-book : Materia Medica, Pharmacy, Pharmacology, and Therapeutics. By Wm. Hale White, M. D., F. R. C. P., etc., Physician to, and Lecturer on Materia Medica at, Guy's Hospital ; Examiner in Materia Medica, Royal College of Physicians and Royal College of Surgeons, etc. American Copyright Edition, edited by Reynold W. Wilcox, M. A., M. D., Professor of Clinical Medicine at the New York Post-Graduate Medical School and Hospital, Assistant Visiting Physician, Bellevue Hospital, etc. To be printed in one compact, handy volume. They also announce

that a German edition of the second revision of Gower's Book on the Nervous System has just been published by Cohen, of Bonn, (Vol. I. has already appeared,) and we understand that an Italian translation is nearly ready.

The April (1892) number of *The Alienist and Neurologist* contains: Surgical Cure of Mental Maladies—Résumé, by Dr. Guiseppe Seppilli, Italy; Some Principles Involved in the Nature and Treatment of Inebriety, by T. L. Wright, M. D., Bellefontaine, Ohio; Art in the Insane, by J. G Kiernan, M. D., Chicago, Ill.; Drug Habituation, by Lucius W. Baker, M. D., Baldwinville, Mass.; Tumor of the Cerebellum, by George J. Preston, M. D., Baltimore; The Epidemic Inflammatory Neurosis, or Neurotic Influenza, by C. H. Hughes, M. D., St. Louis; Pessimism in its Relation to Suicide, by Wm. W. Ireland, M. D., Scotland; Classification of Insanity, by C. G. Chaddock, Traverse City, Mich.; Report of a Case of Transitory Frenzy, by Theo. Diller, M. D., Pittsburgh; Intermittent Paralysis, by L. Bremer, M. D., St. Louis. Besides the usual selections, editorials, hospital notes, reviews, etc.

The Dios Chemical Co. publishes a chart of cerebral localization in colors, according to the authority of Horsley, Beever, and Schafer. This chart will be furnished free on application to the publishers, 914 Locust street, St. Louis, Mo.

The J. B. Lippincott Company, of Philadelphia, announce that Vol. II., Regional Anatomy, by Dr. Geo. McClellan, is now ready for distribution to the subscribers to that admirable work. As it is only sold on subscription, prompt orders are desirable.

It will be of great interest to the profession to learn that Southern Pines, N. C., the new health resort for consumptives, is so located as to be the best known spot during the summer months for those suffering from throat and pulmonary diseases, hay fever and similar maladies. The place is said to be entirely free from malarial influences, and during summer weather patients experience a greater benefit than at any other season, probably due to the fact that the warmth of summer causes the atmosphere to be loaded with the balsamic qualities of the pines. The testimony of physicians of experience would seem to warrant a trial of this resort in cases where a change of climate is desirable. The thermometer rarely goes above ninety degrees in the shade.

Notice to Contributors.—We are glad to receive contributions from every one who knows anything of interest to the profession. Articles designed for publication in the Journal should be handed in before the first day of the month. The Editors are not responsible for the views or opinions of contributors. All communications should be addressed to the Managing Editor, 284 Franklin St., Buffalo, N. Y.

Buffalo Medical and Surgical Journal

Vol. XXXI. JULY, 1892. No. 12.

Original Communications.

AN OVERLOOKED FACTOR IN THE PRODUCTION OF CONJUNCTIVITIS.[1]

By JULIUS POHLMAN, M. D., Buffalo, N. Y.

We are told by ophthalmologists that the eye when exposed to artificial illumination depends upon three distinct qualities of the light for its well-being, namely, (1) its whiteness, (2) its steadiness, and (3) the amount of heat which it radiates.

Hardly anybody will dare to underestimate the importance of the whiteness and the steadiness of a light. Optic nerves are organs specialized to receive sunlight, and hence the nearer the artificial illumination resembles it, *i. e.*, the whiter it is, the more the eyes remain in their natural condition; and the labor of the optic nerve, to adapt itself to the artificial surroundings, by means of muscular exertions, is reduced to a minimum to the advantage of the eye as a whole.

When we consider the function of the iris, to regulate the quantity of light which is to strike the retina and to reduce the variations of that quantity to the minimum, we can understand how a flickering flame, no matter how white, necessitates an immense strain upon this delicate muscular apparatus, a strain which increases with the unsteadiness of the light.

The third factor, however, the heat which the light radiates, in its influence upon the eye, does not seem so plain. We are taught that heat affects the conjunctiva, and that conjunctivites are often found in occupants of poorly ventilated rooms where hot lights are burning more or less all day; and that certainly seems to demonstrate the correctness of the theory. Nevertheless, how *heat*, *i. e.*, a simple difference in temperature, should injure the conjunctiva enough to produce pathological conditions, has never seemed quite

1. Read at the meeting of the Alumni Association Buffalo University Medical College, May 3, 1892.

clear to the writer, because, if this depended merely upon a quantity of *heat*, then why should a temperature of 75° or 80°, produced by gas flames injure the conjunctiva, when a summer heat of 95 or 100°, or even more, does not? If simply a question of temperature only, then the effects ought to be the same, no matter what the source of the heat, because the whole eye is subjected equally to its influence and not a small part of it alone; were it otherwise, we may defend the apparent difference in the effects of natural and artificial heat on the same lines as we differentiate between wind and draught: one striking the whole body, the other only a circumscribed portion of it, thus having differing conditions with differing results. But this line of reasoning cannot be applied to the eye. As, however, the effect produced on the eye by the heat of artificial light *does* differ from that produced by natural heat, we must look for other or additional causes which injure the conjunctiva.

Dr. Frank P. Vandenbergh, for many years City Chemist of Buffalo, informs me that the manufacture of light gas in this city is rather behind the times; made from bituminous coal by the old-fashioned process of dry distillation, it always contains a considerable quantity of sulphur; for instance, the average of numerous analyses shows that the product of the Buffalo Gas Light Company has 12.08 grains of sulphur in every 100 cubic feet of gas; the Mutual Company, 12.93 grains, and the Citizens' Company, 9.68 grains. That means that for every 100 cubic feet of gas burned, ten to twelve grains of surphur are given to the air in the form of fumes, which, as we all know, have a special affinity for moist surfaces forming their sulphurous acid.

Several years ago the leading librarians of the country made quite extensive reports upon the corroding influence of gas light upon the leather bindings of books. If the sulphur compounds can corrode leather in the course of time in large well-ventilated libraries, are we not justified in assigning some influence to them when acting on the moist conjunctiva in a poorly-ventilated room with gas burning, perhaps, all day, or throughout the time when the eyes are exposed to the heat of the flame?

It may be quite appropriate here to mention that the natural gas used in Buffalo contains no sulphur, and will, therefore, with the right kind of burner, produce a light superior to that of artificial gas as far as any injurious effect upon the conjunctiva is concerned.

More important, however, to the eye than this small amount of sulphur is the quantity of moisture which air holds under varying temperatures. It is an old and well-known fact that the hotter the air, the larger the amount of water which it contains, and the lower the temperature the smaller the amount, all other things being equal. Supposing a room contains a certain amount of moisture at 50° when the outside air is 40°, then, if we raise the temperature of the room to 70°, we must supply a certain amount of water for evaporation in order to have the air and warmth feel agreeable, *i.e.*, not too dry; for the outside air coming in at a much lower temperature is still drier than that contained in the room originally, and we must resort to artificial means in order to supply the demand.

Artificial heat in its drying effect upon furniture, doors, etc., has often been discussed, but it seems that such discussions have always stopped at dead matter and have never been applied to living bodies.

To investigate the effects of the *dryness* of the air on the conjunctiva, the following experiments were made:

The room used was 12 x 13 feet, 9 feet 6 inches high, and heated by natural gas burned in an open front Jewett gas burning stove; this particular kind of stove has a water-tank at its back which holds two quarts of water, and forms part of the structure, so that the flames play directly against one side of it. When running at full blast, to keep the room at 65° to 70°, the contents of the tank evaporated in about six hours; in other words, it took about two gallons of water in twenty-four hours to keep the air of the room supplied with the moisture necessary for its temperature when it was freezing outside.

The ventilation of the room and the draught of the stove were perfect, and no product of combustion, complete or incomplete, or other gases of any kind from leaks in pipes or otherwise, could enter the room and mix with the air; all sources of error in this direction were avoided as carefully as possible, so that the effects produced upon the eyes of the occupants of the room were due solely to the peculiar condition of its atmosphere and to nothing else.

The experiments were made at thirty different times, lasting from thirty minutes to two hours each, upon the writer's own person. The effects produced were repeatedly corroborated by visitors who happened to call at such times, and who knew nothing

about the experiments to which they were unconsciously subjected during their visits; hence, their complaints would have to be called entirely unbiased and unprejudiced, but their symptoms were always identical with those experienced by the writer.

With a temperature of 65° or 70° when the water-tank on the stove was empty and the air of the room relatively dry, an exposure of fifteen minutes made the eyes feel dry and sticky; if prolonged for another fifteen minutes, or if the temperature was raised to 80° or 85°, the symptoms became more decided,—the peculiar sensation of a foreign body in the eye, like a particle of sand or some stringy substance, became very strong. The conjunctival vessels of the lids looked engorged, the more the longer the exposure, and after a stay in a dry atmosphere of 80° for about two hours, the conjunctival vessels of the bulb were equally well marked, and the eye presented in every symptom a well-developed case of acute conjunctivitis.

While cold has a stimulating effect upon the lachrymal gland, heat apparently does not act in that way; whether it has an inhibitory function, is not yet decided, but it certainly does not increase the secretion, and though the ordinary amount of lachrymal fluid is sufficient to keep the eye moist and clean under ordinary conditions, the gland does not secrete fluid enough when the air is too dry for its temperature, and hence calls for a more rapid evaporation from all moist surfaces. The eye tries hard to overcome this deficiency by increased winking, but to no avail; evaporation from the conjunctiva proceeds quicker than the moisture is supplied by the lachrymal gland, and its surface becomes proportionally dry, producing after awhile all the disagreeable sensations of conjunctival troubles.

Whether the mechanical irritation produced by the friction of the dry conjunctival surfaces has the effect of dilating the capillaries and producing in this wise a slowing of the blood stream with the attending phenomenon of engorgement, or whether the heat has such an effect upon the partially dry eye which it would not have upon the normally moist organ, or whether there are other causes which, by themselves or in addition to those mentioned, produce the engorgement, must be left for additional investigations to decide, but that the acute conjunctivitis, mild or severe, was caused by the *dryness* of the air and not by the *heat*, was demonstrated during every experiment as follows:

Whenever, during the course of an experiment, the water-tank

on the stove was filled, and free and rapid evaporation restored the equilibrium between heat and moisture, then, no matter whether the temperature of the room was 65° or 85°, the annoying symptoms disappeared in a few minutes if the exposure had not been too prolonged. In the early stages of the experiments, just when the eye commenced to feel sticky, a simple dropping of a few drops of water between the lids caused an almost instantaneous disappearance of the distressing sensations, but they returned equally promptly, and with unvarying certainty, if the eye was again exposed to the dry air. If bathed continually, no matter how hot or how dry the air, the eye felt as comfortable as under normal conditions, and none of the symptoms appeared as long as the conjunctiva was supplied with the required moisture.

What happens in the room as a whole, will take place on a smaller scale in the vicinity of a lamp, the temperature is raised and the air is dried correspondingly, and whenever the eyes are near enough to the flame to feel its heat, they will be affected by the dryness of the air, and the hotter the light the dryer will be the air that surrounds it.

If additional observations prove this theory to be correct, then we can understand why a summer temperature of 95° or 100°, holding its normal quantity of moisture, has no effect on the eye, while artificial heat of 70°, with its usual corresponding dryness, can produce very decided forms of conjunctival troubles, and we learn that a little closer attention to the water-pan on the furnace or on the stove, is as necessary to the well-being of our eyes as the efficient lighting of the room. And if repeated experiments finally develop the fact that heat has no effect upon the conjunctiva, then we have to modify our teaching regarding the well-being of our eyes under artificial illumination, and name as the three factors necessary, whiteness and steadiness of the light, and moisture in the air surrounding the flame proportionate to its temperature.

367 Franklin Street.

Pie-Plant and Hematuria.—A number of cases of urinary trouble following the free eating of rhubarb, or pie-plant, have been reported. They are attended by the symptoms of oxaluria—frequent and painful micturition, hematuria, and lumbar pain. The trouble arises from the oxalic acid contained in the rhubarb uniting with the calcium of drinking water, and a consequent formation of the oxalate crystals in the uriniferous tubules.—*Doctor's Weekly.*

SIX CASES OF ABDOMINAL SECTION.[1]

By M. A. CROCKETT, A. B., M. D.,

Assistant Gynecologist to the Buffalo General Hospital; Gynecologist to Fitch Dispensary; Instructor in Obstetrics and Gynecology, Medical Department, University of Buffalo.

In these days, when laparatomists count their operations by the hundred, it seems rather presumptuous for me to present a report upon a paltry half dozen cases. In connection with some of these patients, however, there are a number of interesting features which, I trust, will justify me in asking your attention for a short time this evening.

I have been fortunate enough to have no deaths thus far. In two or three cases, stitch-hole abscesses occurred; otherwise the recoveries were uneventful.

Numbers one, three, and six were ordinary cases of chronic salpingitis and ovaritis. Each of these patients had been ill for from two to five years, and had received treatment from a number of physicians. They belonged to the class commonly designated as "wrecks," and despaired of ever obtaining relief from their sufferings. The operations were of ordinary difficulty, the adhesions being numerous in each case, and the specimens removed fully justifying the treatment. The tubes and ovaries presented the lesions of chronic inflammation, *e. g.*, closure of fimbriated ends, hydrosalpinx, cirrhosis, and cystic degeneration of the ovaries, rendering these organs physiologically useless and sources of misery to their possessors.

As regards the ultimate results, it is, unfortunately, rarely possible to follow up hospital cases. It is also the fact that the benefits of operation are not always immediate. Number one had improved greatly before leaving the hospital. The second patient was in good health six months after operation. The third patient has not yet been discharged, but is doing well in every respect.

It is not the place here to discuss the question of removal of the uterine appendages. The subject, periodically, occupies considerable space in our journals, and too often is the cause of exhibitions of bitterness and prejudice by no means creditable to the profession.

I would only ask you to consider each case on its individual merits. "It is a condition and not a theory which confronts us." Very often the patient has to choose between operation and the almshouse.

1. Read before the Buffalo Clinical Society, May 14, 1892.

How useless, in such cases, to talk about treatment by electricity, local applications, massage, tonics, rest, etc., when such treatment cannot be obtained by our patient. By operation these women hope to return to health by a short cut. Unfortunately, sometimes this short cut turns out to be a rough and dangerous path, and may even prove to be no thoroughfare at all. On the other hand, in many cases operation results in a rapid and complete cure. Let us, therefore, try to be fair to an operator, and not condemn until we know the facts.

Case number two is a rather remarkable recovery from a severe operation. The history is as follows :

Age, twenty-five ; married one year ; never pregnant. Clear history of gonorrheal infection previous to marriage. Brought to the hospital flowing profusely, and suffering from severe abdominal pain. Patient attributed her trouble to exposure to cold during her last menstrual period.

Vaginal examination showed a retroverted uterus with large fluctuating masses on either side. After a few days the temperature presented a typical pus curve, and a diagnosis of pyosalpinx, probably gonorrheal, was made. Operation August 29, 1891, Dr. Parmenter assisting. The adhesions were numerous and very vascular. The right tube and ovary had to be torn loose from vermiform appendix, small intestines, floor of pelvis, etc. The ovary was converted into an abscess the size of a hen's egg. The tube resembled a small sweet potato, and contained several ounces of pus.

On the left side everything was buried in adhesions. Attempts to free the tube resulted in tearing off small pieces : the consistency being like that of wet blotting paper. Everything in the pelvis was floating in pus, and the condition of the patient became extremely bad. A considerable portion of the tube remained behind in the bottom of the pelvis. The pelvis was sponged out and the abdomen irrigated. At Dr. Parmenter's suggestion, the abdomen was left half full of hot water. This procedure had a very happy effect upon the pulse, and the patient began to rally at once. Finally, a glass drainage tube was inserted, and the wound closed.

This temperature chart shows you the condition of the patient before and after operation. You will notice that for a week before operation her temperature at evening varied between 101° and 103.4°. During the first eighteen days subsequent to operation her temperature did not touch 100°, except on the eighth day, when a stitch-hole abscess caused a temporary rise. The temperature fell again upon evacuation of the pus. Considerable pus dis-

charged through the drainage tube, which remained in place for forty-eight hours.

I was much surprised at the toleration shown by the peritoneum in this case. This pus caused marked constitutional disturbance before operation, and yet no bad result followed its escape from the tube. The discharge from the drainage tube showed that the pelvis was not clean after operation. The recent investigations of Wertheim (*Archiv. für Gyn.*, Bd. XLII.), show that the gonococcus alone can produce pus, and that mixed infection is not necessary in order to explain gonorrheal pyosalpinx. He also shows that the gonococcus affects the peritoneum only to a very limited extent. I think these ideas afford some explanation of the favorable course of this case. When the patient left the hospital, no evidence of any pelvic trouble could be found on vaginal examination.

Case number four shows how difficult it is, sometimes, to diagnosticate intra-abdominal lesions. I first saw the patient in September, 1891, and obtained the following history:

Age, seventeen; single. Last menstrual period, ten weeks ago. Five weeks ago she noticed that her abdomen was increasing in size. At times, usually at night, she had severe pains in this "swelling." The patient was very anemic-looking, and her face drawn and haggard. The enlargement of the abdomen was very marked. Palpation disclosed a smooth, hard, rounded tumor, reaching almost to the level of the umbilicus. The tumor was movable, and not at all sensitive, unless deep pressure was made slightly above the left groin.

Two fingers could easily be introduced into the vagina. The cervix was low down, and the tumor could be felt on all sides. I concluded that I had to do with a uterine tumor, but was not at all clear as to its nature. The patient was sent to the hospital ward of the Ingleside Home, under the care of Dr. Lillian C. Randall. The patient's temperature was taken a number of times, and on each occasion found to be normal.

Later, Dr. Mann saw the case. His opinion was that the tumor was sarcomatous, and as the general condition was then very bad, I gave an unfavorable prognosis to the family.

About a week later, I was informed that the tumor had suddenly disappeared, and an examination showed that certainly three-quarters of the mass had vanished. There remained, however, a distinct tumor on the left side of the uterus, which now could easily be made out. The patient's general health rapidly improved, and six weeks later she went home. No further change in the local conditions had occurred. The patient had not menstruated during her stay in Buffalo.

About one month later the patient returned, complaining of severe

pains in the left side. She was absolutely unable to do any work and desired an operation.

Examination showed a firm, rounded tumor, the size of the closed fist, lying on the left side of the uterus. Patient had had a normal menstrual period while at home.

Operation January 29, 1892, Dr. Mann kindly helping me. The mass on the left side was easily reached. Its surface was perfectly smooth, as though it were covered by the distended broad ligament. On cutting through this covering with the idea of enucleation, it was found to consist of almost half an inch of inflammatory tissue. While working my way downward there was a sudden gush of vile smelling pus, and from the midst of this tissue this tube and wreck of an ovary was dug out.

The right tube and ovary were adherent, and showed signs of permanent pathological changes. They were therefore removed, drainage tube inserted, and abdomen closed. The subsequent history is of no especial interest. The patient left the hospital free from pain, and feeling quite well.

I have here the appendages from this case. The left ovary is represented by the remains of this sac. The tube contained a small amount of pus near the fimbriated end. I cannot tell whether I ruptured the pus sac during removal, or whether the pus had already escaped; the other ovary, as you see, is very large. The end of the tube was closed, but it contained no pus.

I presume the large mass originally present was entirely inflammatory. The case was seen by a number of physicians, and no one suspected for a moment the true state of affairs. The rapid disappearance is attested by several reliable observers, but the fact has never been satisfactorily explained. The patient's subsequent history is uninteresting. She was quite well in every respect when discharged from the hospital.

The last case which I wish to report (number five) is one of extra-uterine pregnancy. The specimen, which I show you, is certainly very perfect.

Patient aged twenty-seven; married eight years; two children, the last born five years ago; no abortions. Menstruation has always been rather profuse, and sometimes occurred at greater intervals than twenty-eight days. The patient has had good health, and never complained of any local or general disturbances. She menstruated December 14, 1891, but not at all in January, 1892, and, therefore, believed herself to be pregnant. About the middle of February she was seized with a sudden and severe attack of cramps in the abdomen, and, as a result, was confined to her bed for over a week. On attempting to get up and

attend to the house, the abdominal pains returned, and from this time on she was obliged to remain in bed. About the first of April she was seen by Dr. Mann, who made a diagnosis of probable extra-uterine pregnancy, with rupture of the sac. Soon after she entered the Buffalo General Hospital for treatment. Owing to Dr. Mann's illness the case was turned over to me. I examined her about the latter part of April, and found the following conditions present:

A large mass could be felt to the right of the uterus, displacing that organ towards the left. Bimanual examination showed the tumor to be about the size of a cocoanut. It rose high enough in the pelvis to be felt by the outside hand alone.

Operation was performed May 2, 1892, Dr. Parmenter assisting.

A number of coils of small intestines had to be separated from the top of the mass before the hand could be introduced. An extensive raw surface was left upon the gut, and in one place sutures through the peritoneal coat were deemed necessary. The right tube merged into the tumor and was tied off. By slowly working down under the tumor with the fingers, the mass was removed entire, a large area of raw surface being left behind, and for a time the oozing was considerable. The patient being in Trendelenburg's position, I was enabled to secure the largest vessel, and pressure with sponges soon checked all further bleeding. The abdomen was closed without drainage.

Examination of the specimen shows that it had evidently ruptured from the tube into the broad ligament, from which it was enucleated. The bulk is more or less organized fibrine. I have laid open the amniotic sac, which shows plainly. The fetus is about three and a half months old, and is hanging by the cord from the placenta. I will pass around the temperature chart. Today is the thirteenth day, and the temperature has never been above 100°, except one evening. Considering the extensive raw surface necessarily remaining in the abdomen, the temperature curve is rather remarkable. The wound has united by first intention, and I shall allow the patient to sit up tomorrow.

DEATHS FROM INFLUENZA.—Dr. Lewis A. Balch, the Secretary of the State Board of Health, estimates that 10,000 deaths in the State of New York were chargeable to influenza and its sequelæ in the Winter quarter of 1892. The local diseases appear to bear the brunt of a largely increased mortality, but influenza is, probably, the genuine cause.

THE BACTERIA OF THE MOUTH.—OF INTEREST TO DENTISTS AND OTHERS.

BY FRANK JAY THORNBURY, M. D., Buffalo, N. Y.

THE oral cavity is a favorite location for various forms of micro-organisms. And it is not surprising that this should be the case when we consider the variety of circumstances conducive to bacteria gaining entrance to the mouth.

The principal sources for such access of germs are: Water, uncooked food, air, and certain other causes, active especially in children.

Secondly, we have here all the factors conducive to the growth and proliferation of microbes. There is continued moisture and a uniform temperature, and carbo-hydrates, and albuminous substances, which form the best possible nutrient media for bacteria.

These substances are almost invariably present between the teeth, in the cavities and depressions, and on the gums.

Over 100 different species of bacteria have been detected in the sputum. Many of these have only a transitory presence, but there are certain others constant in the mouth, and whose individual characteristics are now well understood. To Miller are we especially indebted for placing the subject of dental bacteriology on its present advanced basis. To refer to a few of the better known *mouth bacteria*, we would mention (1) Leptothrix innominata as occupying the foremost place in order of importance. It is by reason of its wonderful destructive properties that this bacillus has attracted so *much* attention. It stands in direct causative relation to many diseases of the buccal cavity, and has been known to penetrate the lungs, stomach, and other structures. The teeth themselves are sometimes permeated and disintegrated by this virulent microbe. It occurs in long thin threads, assuming a spiral form, and is found in soft white deposits on teeth in every mouth. With a solution of iodine and iodide of potassium it stains very readily; (2) Bacillus bucallis maximus is second in importance of the mouth bacteria, and occurs in aggregated tufts. Occasionally the individual threads are seen, and sometimes the bacilli themselves; (3) Leptothrix bucallis maxima.—This occurs as long thick filaments, sometimes curved, and is found in mucous deposits upon the teeth; (4) Jodoccus vaginatus.—Occurs singly or in chains of from two to ten cells encapsulated and is found in all unclean mouths; (5) Spirillum sputigenum, is sometimes rod shaped, but

is usually of comma form, and has an active spiral movement. It is found in all mouths, especially where cleanliness is neglected. It is permissible of a staining with iodine solution ; (6) Spirochete dentium forms irregular threads of unequal thickness, and is found under the margin of the gums, when covered with a dirty deposit, or on gums in state of slight inflammation, *i. e.*, gingivitis marginalis.

Linsley has cultivated many additional varieties from the teeth and gums of patients suffering from lesions of the mouth, cases referred to him by dentists for bacteriological investigation. A particle of the suspected material is removed with a sterilized needle and placed in a gelatine or ager tube, after which the cultivation is easily affected.

The organic and inorganic substances found in the mouth, which may be the nidus of bacteria, are : (1) The normal saliva ; (2) Buccial mucus ; (3) Dead epithelium ; (4) Dental tissue softened by acids ; (5) Exposed pulp ; (6) Tartar and exudations on the gums ; (7) Accumulation of particles of food. There are three or four chromogenic or color-producing bacteria in the buccial cavity ; they give a blue or violet reaction with iodine, and form twenty to forty cultivable sub-species, partially non-pathogenic, partially of unknown pathogenesis.

The following pathogenic bacteria have been isolated from the mouth : (1) Micrococcus gingivæ pyogenes ; (2) Bacterium gingivæ pyogenes; (3) Bacillus dentalis viridis; (4) Bacillus pulpæ pyogenes. The first of these organisms was found several times in a case of pyorrhea alveolaris, in the deposits around the teeth of a very dirty mouth. The second was found in the same case and also in a suppurating tooth pulp of a second person. The third variety was found in the superficial layers of a careous tooth. It produces a beautiful opalescent color in its growth. The fourth (bac. pulp. pyog.) was found in a gangrenous tooth and was proved pathogenic by inoculation.

Redness, swelling, abscess, diffuse suppuration, gangrene, general septic infection, with sometimes peritonitis or pleuritis, followed the inoculations—subcutaneous or inter-visceral—of these latter organisms. Mixed cultures are more dangerous than single germs in pure culture. Most disastrous of all are the bacteria of gangrenous pulps. Human saliva possesses most energetic toxic properties, as has been conclusively proven by fatality resulting from bites. Animals, especially white mice, almost invariably

die after inoculation with sputum ; (1) Inoculation of rabbits and guinea-pigs, causes either death or the severest forms of septic infection ; (2) In one instance, where a mouse was inoculated with sputum, and died in eight hours, the writer found the Fränkel-Weichselbaum diplococcus of pneumonia disseminated through the blood ; this germ is nearly always present in the mouth, and all that is necessary for the development of pneumonia is exposure and reduction of the bodily temperature, when the germ takes on activity ; (3) In the presence of any morbid condition as gingivitis, wounds of the mucous membrane, dental caries, ulcerations, etc., the number of bacteria markedly increase. The diseases caused by pathogenic bacteria of the mouth Miller considers under six heads, formulated by Linsley as follows : (1) Infections caused by a solution of continuity in the mucous membrane, brought about by mechanical injuries (wounds, extractions, etc.); (2) Infections through the medium of gangrenous pulp ; these usually lead to the formation of abscess at the point of infection, but may cause secondary septicemia with fatal termination ; (3) Disturbances, produced by the absorption of poisonous products of the bacteria ; (4) Pulmonary disease, produced by the inspiration of particles of mucus, small pieces of tartar, etc., containing bacteria ; (5) Abnormal fermentative processes and other digestive disturbances caused by the swallowing of microbes and their poisonous products ; (6) Local infection of the soft structures of the buccial and pharyngeal cavities induced by mechanical irritation or constitutional debility ; (7) Possible infection through accumulation in the mouth of the germs of diphtheria, typhus, syphilis (?), tuberculosis, etc.

610 Main Street.

As Bromide of Strontium seems to be destined to displace the bromide of potassium, we would specially recommend our readers to insist on having the chemically pure salts (Paraf.-Javal) dispensed, or the standard solutions (one gramme to the ounce), so as to avoid further accidents, as we learn that toxic effects have been caused by the dispensing of impure strontium salts, the poisonous barium being a concomitant of the strontium preparations of commerce.—*St. Louis Clinique.*

Hemorrhage.—Do not use stypties to control hemorrhage, and above all, do not use Monsel's solution (subsulphate of iron), as in case an operation is necessary it obscures the field of operation. The use of hot water is very much better (Prof. Keen).—*Coll. and Clin. Rec.*

Society Proceedings.

NEW YORK ACADEMY OF MEDICINE.—SECTION ON ORTHOPEDIC SURGERY.

Stated Meeting, May 20, 1892.

HENRY LING TAYLOR, M. D., Chairman.

CONGENITAL DISLOCATION OF BOTH PATELLÆ.

Dr. S. KETCH presented a little girl who at first glance seemed to have only knock-knee, but on flexing the limbs, a complete dislocation of the patella downwards and forwards was observed, and the dislocation could be readily reduced by extending the limb. The deformity was much more marked on the right side. The condition was probably congenital, although it had not been noticed by the mother until recently, as the child was able to walk with no more difficulty than is observed in an ordinary case of knock-knee. Dr. Shaffer had suggested that this was the opposite of the condition which he had described under the head of elongation of the ligamentum patellæ at the last meeting of the American Orthopedic Association.

Dr. JOHN RIDLON said that he had seen three such cases in the practice of the late Mr. Thomas. The treatment had consisted in hammering the deficient condyle with an egg-shaped wooden mallet, and in two of the cases, the treatment had already effected sufficient development to prevent dislocation, and in the other case the treatment had only been just begun.

Dr. W. R. TOWNSEND said that he had presented some time ago, to the Surgical Section of the Academy of Medicine, a colored girl who could, by muscular action, produce at will a complete dislocation of both patellæ, either to the outer or inner side. A knee-cap was applied, and an effort made to restrict the movements of the fibers of the vastus externus and internus which seemed to be abnormally developed. She was kept under observation for six or eight months, and at the end of this time she could not produce the dislocation at will, and the dislocation occurred quite infrequently.

Dr. N. M. SHAFFER said that in his case of elongated ligamentum patellæ, the man had had a fall, which was followed by an

outward dislocation of the patella, on the right side. After consultation with several other surgeons, in view of the fact that the intercondyloid notch was filled by an exostosis, it was considered best to make no attempt at reduction, and at present, although the patella lies on the outer aspect to the joint, the man is perfectly able to walk ten or fifteen miles a day. In the case just presented, he did not think the external condyle was deficient, but the ligamentum patellæ was so short that the patella, instead of passing over the trochlea, is drawn down to a point where, owing to the knock knee, it is very easily dislocated. On this account, he thought that treatment directed towards securing an elongation of the ligament would be more apt to prove successful, than simply hammering the outer condyle.

Dr. KETCH, in closing the discussion, said that he agreed with the last speaker as to the inadvisability of resorting to operative measures. Not long ago he had seen a young lady with a somewhat similar condition. Twelve years before, the patella had been dislocated by muscular action, and this had again occurred shortly before he saw her. Reduction was easily effected by extending the limb.

Dr. ROYAL WHITMAN presented several patients :

CASE I. A girl, fourteen years of age, to illustrate the appearances in non-deforming club-foot. As in many similar cases, the history was one of awkwardness in walking for many years, with increased pain and discomfort during the past six months. She presented the calluses on the balls of the feet, the contraction and tenderness of the plantar fascia, and the limitation of dorsal flexion to which Dr. Shaffer had called attention in his original communication.

CASE II. A woman, fifty-seven years of age, who had suffered from chronic rheumatism for many years. On the left side the contraction of the plantar fascia had thrown the foot into a position of equinovarus. There was no deformity of the right foot, but on both sides a well-marked limitation of the dorsal flexion. The electrical reactions were normal. The condition was similar to non-deforming club-foot, and was apparently the result of a rheumatic inflammation.

CASE III. A girl of fourteen, with marked spasmodic flat-foot. The case was presented to illustrate the extreme and progressive deformity and disability in this class of cases, which could be easily and quickly relieved by the method of treatment to which he had on several occasions called the attention of the Society.

CASE IV. A girl of eighteen, with persistent abduction of the right foot. Although there was no evident deformity, the foot was held in

an abducted position by spasm of the peroneii and extensor longus digitorum muscles. The condition was the result of a slight sprain three months before. The symptoms were, pain, fatigue and insecurity, in walking. The case illustrated the condition in so-called chronic sprain of the ankle, which practically never recovered, because the foot being unbalanced by irregular muscular action, was constantly subjected to injury. When the condition was recognized, a cure could easily be accomplished by restoring the normal muscular action. The patient being etherized, the foot should be forced into a position of extreme equino-varus. All adhesions were thus broken up, and the contracted muscles were stretched. The foot was then placed in plaster-of-Paris, and later, by massage, exercises, and a temporary support, the patient could be completely and permanently cured.

Dr. R. H. Sayre thought that in the fourth case there might have been a fracture of the lower part of the fibula, complicating the sprain, which had been overlooked in the treatment of the case immediately after the injury.

Dr. Ketch thought that the fourth case gave evidence of a possible osteitis about the ankle joint, and this condition should be carefully excluded before adopting the treatment proposed.

Dr. Whitman said that he found no indications of an osteitis in the fourth case, and that there was no history or present indication of fracture complicating the original sprain.

Dr. Shaffer said of the second case, that the exaggerated extension of the toes, and the shorter plantar tissues, were characteristic of non-deforming club-foot. He had seen several cases where the symptoms had not become prominent until the age of thirty-five or forty years was reached, and then, whether there was a rheumatic diathesis or not, all the symptoms would be greatly exaggerated. Many cases showed much less deformity than that exhibited in Dr. Whitman's case. The typical non-deforming club-foot showed little or no deformity as such, unless it was sought for and found in the shortened plantar and post-tibial tissues. The lack of proper length prevents normal antero-posterior movement at the ankle and in the tarsal joints, and the entire weight of the body falls upon the "ball of the foot" in locomotion. It is far more common than is generally supposed, and with the use of the antero-posterior traction shoe, there is no necessity whatever for a division of the resisting tissues.

Dr. R. H. Sayre thought the second case presented very much the condition found in ordinary cases of chronic gout and rheum-

atism, and he had noticed that after the foot had been manipulated somewhat, she was able to move it much better than before, and could voluntarily flex the ankle beyond a right angle, so that it did not seem to be a case of non-deforming club-foot.

ANCHYLOSIS OF THE HIP.

Dr. Irving S. Haynes, present by invitation, exhibited a specimen of this condition, which he had found in the dissecting-room of the University Medical College. The subject was a man about twenty-five or thirty years of age. The limb was slightly flexed, adducted, and rotated inwards. A sinus opened about half an inch below Poupart's ligament, and one inch internal to the anterior superior spinous process. It passed backwards, soon divided into two tracts, one leading down to the front of the great trochanter, the other up under Poupart's ligament into the iliacus, and then into the obturator internus muscles; then around the middle of the outer border of the obturator foramen into the cotyloid notch, and so into the hip-joint. The iliacus and obturator muscles, as well as all the muscles acting upon the hip-joint, had undergone extensive absorption and fibrous degeneration. The center of the disease, and the starting point, seemed to have been in the head of the femur, but there was also a focus in the epiphyseal line of the great trochanter, which communicated with that found in the head of the femur by a sinus running through the neck and also opened in front through one or two small openings. Another sinus seemed to have led from the acetabulum through the cancelous portion of the ilium into the iliac fossa, where the opening was surrounded by bony formations. Between the ilium and sacrum there was slight mobility of a gliding nature, which the speaker had never observed before, and which was probably intended to partially compensate for the lack of motion at the hip. There was no evidence of the disease in the capsule of the joint. The abscess cavities were limited to the absorbed portions of the iliacus and obturator internus muscles.

ARTHRITIS DEFORMANS.

Dr. Haynes also exhibited a specimen of this condition, showing erosion and reproduction of bone, with a depression in the acetabulum, and a disappearance of the ligamentum teres. The motions of the joint were slightly limited in every direction. The specimen was removed from an old subject.

THE TREATMENT OF LARGE ABSCESSES IN POTT'S DISEASE.

Dr. W. O. Plimpton presented several cases of Pott's disease with large abscesses as an illustration of the treatment which he advocated. He did not favor aspiration, because he thought after this had been done, the abscesses were likely to continue to enlarge and burrow into the tissues. While admitting that abscesses were not infrequently absorbed, he wished to depreciate the let-alone treatment of large abscesses which tend to burrow deeply into the tissues, threatening to inoculate these tissues, often causing mechanical deformities of other parts.

Case I. A boy about twelve years of age, who had had Pott's disease since he was three years old. The disease followed closely upon a blow from a brick. When he first came under the speaker's care last July, he was very anemic and weak, with an afternoon rise of temperature. There was a very large abscess situated beneath the glutei muscles, and there was much deformity of the leg, viz.: apparent shortening, inward rotation, and adduction—caused by the abscess. Free incision evacuated a large quantity of fluid, together with broken-down tissue. An examination with the finger showed no involvement of the joint. The diseased parts were thoroughly curetted with a Volkmann spoon, a counter-opening made, and three drainage-tubes inserted. After washing out the cavity with a weak bichloride solution, the superficial cavity was obliterated as far as possible by means of sutures, and primary union occurred except at the site of the drainage tubes. Two of the tubes were gradually withdrawn. The third one, in front, still remains in for drainage, although it has considerably shortened. The apparent inequality in the length of the limbs has disappeared since the operation, and with a plaster-jacket to support the spine, he is able to go to school, and to play with other children. The discharge is steadily becoming less.

Case II. A girl, seven years old, whose disease dates back to a fall about three years ago. When first seen one year ago last January, there was a moderately large abscess, which was opened, and a tube six or eight inches long inserted. The tube has been gradually shortened until it is now three inches long; the discharge is diminishing, and the patient's general health has markedly improved. Another case was treated in a similar manner, and has steadily improved since the operation. In all, there had been a gradual reduction of the temperature after the operation. The same precautions were observed as in any cutting operation where it is the intention of the surgeon to secure primary union and after the operation care was taken to keep the wound and dressing aseptic.

Dr. W. R. Townsend said that the location of the tube in the first case reminded him of an accident which occurred about one year ago. He was hastily summoned to the hospital on account of one of the patients having a hemorrhage. He found that a case of large psoas abscess which had been opened and a drainage-tube inserted three weeks before, had suddenly begun to bleed profusely. The hemorrhage was arterial, and with the assistance of Dr. W. T. Bull, he cut down and found that the pressure of the drainage-tube had caused a large perforation in the femoral artery. He accordingly tied the artery above and below the perforation, and the child recovered without further accident.

Dr. Ketch thought the cases presented very much the appearance of those he had seen in the hospital, when it was the rule to open all abscesses as soon as the abscess approached the surface. They did not seem to him to differ materially in their course from those where the abscesses were allowed to open spontaneously, and he could not see that anything had been gained by this method of treatment.

Dr. Ridlon asked if the drainage-tube had been left in for so long a time for fear that the opening would close up, and necessitate another operation. He had always thought that it was not necessary to leave in the tube more than a few days.

Dr. A. M. Phelps thought that the second case had had a decided advantage over the first in being subjected to the operation at a much earlier stage. The slightest increase in an abscess, in his opinion, warranted prompt incision. He spoke emphatically, because the section had almost been committed to the idea that it was better for these abscesses to take care of themselves. But it must not be forgotten that these abscesses were originally collections of tuberculous material, and that when they became infected with pyogenic germs, as almost inevitably occurs, there will be a rapid burrowing of the pus. Another reason for opening these abscesses is that they exert an injurious effect by the internal pressure of the exudate upon the carious foci in the diseased vertebræ, keeping them bathed constantly, and furnishing a fertile source of the subsequent breaking down of these vertebræ, and of a consequent increase in the deformity.

Dr. Ketch thought that the previous speaker had not correctly stated the position of the section on this subject. He thought it would be more correct to say that they took the ground that so

many of these abscesses disappeared spontaneously under proper mechanical treatment, that something more than mere accident was necessary to explain it, and that these collections of pus cause injurious pressure had not been proven. The proof of this would be found in a marked increase in the size of the deformity, but in disease of the dorso-lumbar spine, where these abscesses were the most frequent, this did not occur, and Dr. Myers had recently presented a boy who had had two large iliac abscesses disappear spontaneously, and yet there had been no increase in the kyphos as shown by repeated and careful tracings.

Dr. Shaffer said that extensive observation had taught him that with efficient mechanical treatment, the abscesses of Pott's disease almost uniformly pursue a benign course, and he believed that the time would come when those who now operate will see their error. He had seen in the practice of some of the best surgeons in this city, deaths occur after operating upon just such abscesses. When an abscess is very tense, and there are severe local or constitutional symptoms, all recognize the propriety of incision, but, ordinarily, these abscesses are flaccid and do not cause any such "damming up" and injurious pressure as had been described by Dr. Phelps.

Dr. Whitman could see no good reason for waiting until the abscesses appeared below Poupart's ligament. When first discovered, they should be aspirated, and if this fails, iodoform emulsion should be injected. Surely a method of treating the abscesses of Pott's disease, which yielded in the hands of Bruns fifty successful cases out of fifty-two, and of Fränkel, eighteen out of twenty, was one which deserved a fair trial before resorting to severer measures. If aspiration and the injection of iodoform emulsion proved unsuccessful, the method of evacuation recommended by Barker and Treves with immediate closure of the wound, might be employed before resorting to open drainage.

Dr. Plimpton, in closing the discussion, said that the tube had been left in for free drainage, as it had been found that where it was removed shortly after operation, the exuberant granulations choked up the sinus, and gave rise to a great deal more trouble and discomfort than where the tube was retained. At the time of the operation, he had had in mind the possibility of accident from having the tube in too close proximity to the femoral artery, and in this particular case, there were dense cicatricial barriers between

the tube and the artery. Small, and not readily accessible abscesses should not be interfered with, unless they cause some disturbance, but he would not hesitate, if circumstances seemed to demand it, to open them above Poupart's ligament. The existence of intra-abscess pressure, and its effect upon the general health, was well demonstrated in one case in which he removed about half a pint of the contents of the abscess by aspiration, with the result of causing an immediate return of the child's appetite, and a prompt relief of his pain. He had seen the iodoform emulsion used in a number of instances without apparent benefit. In considering the percentage of abscesses which disappear spontaneously, it must be remembered that many of them are small abscesses, or are nothing but fluid in the joint, so that the statistics on this point are very defective.

A CONTRIBUTION TO THE STUDY OF NON-DEFORMING CLUB-FOOT.

Dr. L. W. Hubbard read a paper with this title.

DISCUSSION.

Dr. Phelps objected to the name, Non-Deforming Club-Foot, on the ground that all cases he had seen presented deformity.

Dr. Shaffer said that when he first called the attention of the profession to this subject, this name had suggested itself to him, because all the conditions of club-foot were present except the deformity which was so slight that it had hitherto escaped observation.

Dr. V. P. Gibney said that the condition described some years ago under the name of metatarsalgia might be confounded with non-deforming club-foot. These patients usually complain of pain after sitting for some time, as in the theatre. He had treated a few cases of non-deforming club-foot by division of the tendon and plantar fascia, over-correction, and retention in this position by plaster-of-Paris for a period of several weeks, and he had not been obliged to resort to extension subsequently. So far as he knew, these cases had not relapsed.

Dr. Shaffer said that in a series of twenty-two cases of metatarsalgia, he had relieved over one-half by the antero-posterior traction shoe alone. The inability to flex the ankle-joint brought the maximum pressure at the point of irritation, and hence, by producing a certain amount of forcible section at the ankle-joint, the pressure

was brought upon other parts, thus removing the constant irritation which he thought was the chief etiological factor. He had permanently and completely relieved marked cases of non-deforming club-foot within one week by three or four applications of his traction apparatus. In some cases, deformity can be reduced at one sitting, but the muscles re-contract slightly, necessitating a more prolonged treatment. He did not believe that tenotomy was necessary in any case of non-deforming club-foot.

Dr. R. S. Sayre had found many cases of metatarsalgia to be dependent upon irritation of the pelvic nerves, and such cases had been relieved by galvanism with one pole over the sacrum, and the other over the ovarian region. In the treatment of non-deforming club-foot, he sometimes employed stretching, and sometimes tenotomy, depending upon the nature of the case. If the tendo Achillis or plantar fascia gave a reflex spasm when stretched to its utmost, while joint pressure was applied, his experience had been that tenotomy was necessary. If no reflex spasm was produced, the contracted tissues could be stretched.

Dr. Ridlon asked if the author considered the woman exhibited by Dr. Whitman, to be a pure non-deforming club-foot, and whether he would expect to fully relieve the disability and restore the full flexion by the use of a stretching apparatus.

Dr. Halsted Myers reported a case of non-deforming club-foot in a man, thirty-eight years of age, in which the etiology was unknown. The symptoms were unusual, in that although the ankle flexion was only stopped at 95°, the principal complaint was that the knee could not be fully extended. The patient also felt that he could not fully extend his thigh without much more effort than on the other side, and also felt that his pelvis was tilted up posteriorly. The man knew nothing of anatomy, yet these symptoms were reasonable theoretically, for shortened gastrocnemii might cause knee flexion, and this, in turn, thigh flexion, and this again, tilting of the pelvis up posteriorly. The shortening of the gastrocnemii was the only deformity apparent, yet the subjective symptoms were so annoying that the patient himself proposed forcible extension and fixation in bed, for months even, if necessary.

Dr. H. W. Berg said that he had seen many of the cases on which Dr. Shaffer's first paper was based, and not a little credit was due to him for having distinguished these cases from those of

chronic rheumatism. Most of those described in the paper of the evening have been so quickly relieved, that he was inclined to think they were not congenital, for, after such a condition had lasted for many years, it did not seem reasonable that they should be relieved by one or two stretchings.

Dr. HUBBARD, in closing the discussion, said that he had never seen a case of non-deforming club-foot which he thought would consent to an operation for the relief of the difficulty, as the patients did not ordinarily consider it of much importance. Nor could he recall a single case which had not been materially relieved after one or two stretchings, except in those which were rheumatic.

In answer to Dr. Ridlon, he would say that he considered the case presented by Dr. Whitman, a typical one of non-deforming club-foot of a rather pronounced type, but he had seen as bad, and even worse cases, relieved by persistent stretching. The treatment was prolonged in some instances by the re-contraction of the muscles, but just as india rubber yields after a certain number of stretchings, so these cases will be permanently relieved after the continued use of the traction shoe. In the case referred to in the paper, the condition had lasted for a long time, and the muscle was well developed, and the time of treatment was still further prolonged by the patient's intolerance of the stretching.

A NEW APPARATUS FOR OVERCOMING THE ABDUCTION OF THE THIGH IN HIP-JOINT DISEASE.

Dr. NEWTON M. SHAFFER exhibited a new apparatus which he had devised for the purpose of overcoming the abduction of the thigh in hip-joint disease, and at the same time avoiding the infliction of any traumatism upon the joint. It consisted of a thoracic attachment to the ordinary long hip splint, with an arrangement of curved levers actuated by a key, by which motion is imparted to the limb in a direction downwards and inwards, instead of as in other instruments of this class, inwards and upwards. This is the chief feature, and it is on this account that traumatism is avoided. It can be attached to any ordinary long traction splint, and like the thoracic part, it is to be used only as a temporary arrangement for reducing the deformity.

Dr. PHELPS said that he was glad to see that Dr. Shaffer had come to recognize the fact that we cannot act upon the hip-joint with any degree of precision without taking hold of the thorax:

but he failed to see any necessity for such an apparatus in our armamentarium, as his lateral traction splint did the same thing, and no case of hip-joint disease need recover with angular deformity. Since he had devised and made use of his lateral traction fixation splint, which acts on the same principle as the apparatus just exhibited, he had not seen a case in his practice of angular deformity. If such a thoracic splint be applied after the deformity has once been overcome, recovery must take place without angular deformity.

Dr. SHAFFER explained that the apparatus he had just presented was intended only as a temporary apparatus for overcoming persistent abduction of the thigh, and he considered it a very serious mistake to use the thoracic attachment in the ordinary treatment of hip-joint disease, because it limited the motion of the spinal column, and this would necessarily increase the strain upon the diseased joint. It was for this reason that he had discarded the thoracic addition to the hip splint many years ago. The idea of his new apparatus is to provide a temporary means of overcoming abduction, and it is only to be worn long enough to accomplish this purpose, and then it is so arranged that the abduction and thoracic portions can be readily removed, leaving the ordinary hip-splint, which permitted a free movement of the dorso-lumbar spine, and thus diminished the traumatism at the hip, which is best shown when a patient with hip-joint disease and dorso-lumbar caries attempts locomotion.

BUFFALO ACADEMY OF MEDICINE.

CONSTITUTION.

ARTICLE I.—NAME.

This association shall be called "The Buffalo Academy of Medicine," and shall be composed of resident, non-resident, and honorary fellows, and benefactors.

ARTICLE II.—OBJECT.

The object of the Academy shall be the promotion of the science and art of medicine, including the maintenance of a medical library and a museum.

ARTICLE III.—MEMBERS.

SECTION 1.—The membership of the Academy shall be composed of the present active members, in good standing, of the Buffalo Medical and Surgical Association, the Buffalo Obstetrical Society, the Buffalo Pathological Society, and the Buffalo Clinical Society.

SEC. 2.—Hereafter each candidate for resident fellowship must have been a graduate in medicine, in active practice, for the two years last preceding the application, and must be a resident of the City of Buffalo.

SEC. 3.—Resident fellows removing from the city may become non-resident fellows by vote of the council; upon resuming residence in the city they may be re-admitted to resident fellowship in the same way.

SEC. 4.—Surgeons and medical officers of the United States Army, Navy, or Marine Hospital Service, and physicians residing outside the City of Buffalo, may be admitted as non-resident fellows, and on becoming residents of the city they may, on payment of the difference in initiation fees and by vote of the council, be elected resident fellows.

SEC. 5.—Honorary fellows must be men of eminence, distinguished in science. They shall be chosen by vote of the Academy upon recommendation of the council. The number of honorary fellows shall be limited to twenty-five.

SEC. 6.—Any person having rendered illustrious service to the Academy may be elected a benefactor, by vote of the Academy, upon recommendation of the Council.

ARTICLE IV.—OFFICERS.

SECTION 1.—The officers of the Academy shall consist of a president, four vice-presidents, a secretary, a treasurer, three trustees, and a board of councillors, which shall consist of the aforementioned officers and the secretaries of the various sections.

SEC. 2.—The President shall be elected by the Academy, by ballot, for the term of one year.

SEC. 3.—The vice-presidents shall be the chairmen of the sections on medicine, surgery, obstetrics, and pathology; they shall be elected as each section may designate.

SEC. 4.—The Secretary shall be elected by the Academy, by ballot, for the term of two years.

SEC. 5.—The treasurer shall be elected by the Academy, by ballot, for the term of one year.

SEC. 6.—The trustees shall be elected by the Academy, by ballot, for a term of three years, one being elected and one retiring each year. At the first meeting of the trustees they shall draw lots as to their respective terms of office.

ARTICLE V.—SECTIONS.

SECTION 1.—The Academy shall be divided into sections as follows: A section on general medicine (including materia medica and therapeutics), now known as The Buffalo Clinical Society; a section on surgery (including ophthalmology, otology, laryngology, genito-urinary and orthopedic surgery), now known as The Buffalo Medical and Surgical Association; a section on obstetrics and gynecology, now known as The Buffalo Obstetrical Society; a section on anatomy, physiology, and pathology, now known as The Buffalo Pathological Society; and as many more as may at any time be proposed by ten resident fellows of the Academy, and be approved by vote of three-fourths of the resident fellows present at a stated meeting.

SEC. 2.—Each resident or non-resident fellow at the time of his election, shall designate to the president of the Academy what section or sections he wishes to join, and shall be assigned, by the president, to such section or sections, and shall become a member of the same upon complying with the requisitions for membership in such section or sections.

SEC. 3.—Each section shall prescribe its own requirements for admission and other regulations for its government, provided that none of them is antagonistic or contrary to the regulations of the Academy.

ARTICLE VI.—DISCIPLINE.

SEC. 1.—The Academy may expel or suspend a fellow for violation of its regulations.

SEC. 2.—A three-fourths vote of the resident fellows present shall be necessary to expel or suspend a fellow. This vote shall not be taken unless the printed call for the meeting contains a notice to suspend or expel a fellow.

ARTICLE VII.

Each fellow of the Academy shall be furnished with a copy of the Constitution and By-laws.

ARTICLE VIII.—AMENDMENTS.

No part of the Constitution shall be altered or amended except by a vote of three-fourths of the resident fellows present at a stated meeting, subsequent to one at which a proposition to that effect shall have been made in writing. Notice to this effect shall be included in the call for this meeting.

By-Laws.

I.

MEETINGS.

SECTION 1.—The stated meetings of the Academy shall be held quarterly, in the months of September, December, March, and June, on such day as the council may determine.

SEC. 2.—The annual meeting, for the election of officers and the reading of annual reports, shall be held in June, one week after the stated meeting in June.

SEC. 3.—Special meetings may be called at any time by the president, and shall be called upon the requisition, in writing, of ten of the resident fellows.

SEC. 4.—When practicable, three days' notice shall be given for special meetings, and no business shall be transacted at such meetings except that stated in the call.

II.

QUORUM.

At all meetings fifteen resident fellows shall constitute a quorum.

III.

ELECTION.

At the stated meeting in March, all nominations for the officers to be elected by the Academy shall be made, to be voted for by ballot, between the hours of 4.00 and 6.00 P. M., on the day of the

annual meeting in June. The candidate receiving the highest number of votes cast shall be declared elected. No fellow whose annual dues remain unpaid shall be entitled to vote.

IV.

REPORTS.

At the annual meeting in June, a report shall be presented by the council, by the secretary, by the treasurer, by the trustees, and by each section on the work it has done during the year, the annual address of the retiring president shall be delivered, and the newly elected officers shall be duly installed.

V.

BUSINESS.

The sections shall bring before the Academy at its stated meetings, or as otherwise ordered, such matters as pertain to the several departments respectively assigned to them, as subjects for discussion or other action. They shall severally examine and report on all papers, documents, instruments, etc., submitted to them, and give a brief abstract of the proceedings of the section. They shall each furnish a paper, or prepare a discussion for a stated meeting of the Academy once a year.

VI.

THE PRESIDING OFFICERS.

The president shall preside over all meetings, appoint all committees not otherwise provided for, announce the results of all votes, and be, ex-officio, a member of all standing committees.

VII.

SECTION 1.—The vice-presidents shall assist the president in the discharge of his duties. At any stated meeting, in the absence of the president, that vice-president shall preside who is chairman of the section presenting the programme of the evening.

SEC. 2.—At the annual meeting, or at any special meeting, in the absence of the president, the vice-presidents shall preside in the following order: Chairman of section on medicine, chairman of section on surgery, chairman of section on obstetrics, chairman of section on pathology.

VIII.

SECRETARY.

SECTION 1.—The secretary shall keep minutes of the proceedings of all meetings, issue notices of meetings, notify officers and members of committees of their appointment, transact such other business as may be ordered by the Academy or council, and shall be, ex-officio, a member of all appointive committees.

IX.

TREASURER.

SECTION 1.—The treasurer shall receive the initiation fees and signatures of newly admitted fellows, receive all dues and assessments, keep a correct account of all money received and expended, give a statement of all funds of the Academy in his care to the council or the Academy annually, and whenever requested by either.

SEC. 2.—He shall report to the council the names of all fellows who are one year, or more, in arrears for dues.

X.

TRUSTEES.

The trustees shall have charge of all real estate which is now in, or may at any time come into the possession of the Academy. It shall be their duty to invest the funds of the Academy, report the investment and condition of the funds and property aforesaid to the council when required, and annually to the Academy. All funds and property in their care shall only be used as specified by the donors. All checks and all orders withdrawing deposits from any bank, trust company, or money institution, shall be signed by the chairman of the trustees.

XI.

COUNCIL.

The council shall supervise the general affairs and interests of the Academy, and provide suitable accommodations for its meetings and its movable property, and for its business transactions. It shall estimate for any annual assessment, and shall annually audit the financial account. It shall appoint the librarian and the custodian of the museum. A majority of the council shall constitute a quorum.

XII.

NEW MEMBERS.

Each candidate for resident or non-resident fellowship shall sign an application in writing, endorsed by two resident fellows personally acquainted with him. He shall be elected, by ballot, by the Academy upon recommendation by the council. An affirmative vote of three-fourths of the resident fellows present at a stated meeting shall be necessary to elect.

XIII.

FINANCE.

SECTION 1.—Each resident fellow, upon admission, shall pay an initiation fee of $10.00, which shall include the first year's annual dues; each non-resident fellow, an initiation fee of $3.00. These moneys shall go to the building fund, the principal, or interest, of which may be used for the construction or maintenance of the Academy.

SEC. 2.—The annual dues of each resident and each non-resident fellow shall be $5.00, payable in the month of September.

SEC. 3.—Any fellow failing to pay his dues for one year or more, shall be liable to forfeit his fellowship.

XIV.

MISCELLANEOUS.

Every duly elected resident fellow shall sign the constitution and by-laws within two months after election, and in default thereof, such election shall be deemed void, unless a reason satisfactory to the council shall be given.

XV.

No one elected a resident or non-resident fellow shall be entitled to the rights and privileges of fellowship until the initiation fee shall have been paid, and the constitution and by-laws signed.

XVI.

A copy of every memoir, discourse, or paper, read before the Academy shall be kept in its archives by the librarian.

XVII.

A volume of transactions shall be published under the supervision of the council, when ordered by the Academy.

XVIII.

SECTION 1.—The following shall be the order of business at the annual meeting:

1. Reading of the minutes of last annual meeting.
2. Reading of annual reports of council, of secretary, of treasurer, and of trustees.
3. Report of sections in their order: Medicine, surgery, obstetrics, pathology.
4. Address of retiring president.
5. Installation of newly elected officers.
6. Adjournment.

SEC. 2.—The following shall be the order of business at the stated meetings:

1. Reading of minutes of last stated meeting, and of all special meetings held since the last stated meeting.
2. At March meeting, nomination of officers.
3. Propositions for fellowship.
4. Admission of new fellows.
5. Reading of papers and discourses.
6. Appointed debates and discussions.
7. Unfinished business.
8. New business.
9. Adjournment.

XIX.

No fellow shall have the privilege of speaking more than once on any question under consideration, except by permission of the Academy.

XX.

AMENDMENTS.

These by-laws may be suspended by unanimous vote at a stated meeting; they may be repealed or amended by a three-fourths vote of the resident fellows present at a stated meeting, provided that notice of the same has been given, in writing, at a previous stated meeting, and has been announced on the call for the meeting when the vote is to take place.

XXI.

RULES.

Robert's "Rules of Order" shall be accepted as a parliamentary guide in the deliberations of this Academy.

Adopted at a joint meeting of the Buffalo Medical and Surgical Association, Buffalo Obstetrical Society, Buffalo Pathological Society, and Buffalo Clinical Society, held May 17, 1892.

WM. C. KRAUSS, M. D.,
Secretary.

DeLANCEY ROCHESTER, M. D.,
Chairman.

Progress in Medical Science.

OPHTHALMOLOGY.

BY ALVIN A. HUBBELL, M. D.

AN INSTRUMENT FOR THE DETERMINATION OF CONVERGENCE, POWER AND THE POSITION OF REST OF THE EYES.

M. STRAUB, of Utricht, *Ophthalmic Review*, April, 1892, describes an instrument for rapidly testing the latent position of the eyes in distant and near fixation, which consists of an oblong mirror, sixteen by four centimeters, attached to a narrow ribbon, furnished with a centimeter scale. The ribbon is about one and a half meters in length, and has a black rule fastened to one end. It is applied as follows: A small ink-spot is made on the bridge of the patient's nose between the eyebrows, and he is seated opposite to the observer with his back to the window. The observer holds the mirror with the left hand against his own forehead, with its long axis horizontally, so that the patient can look in it. The mirror must then be turned on its horizontal axis, enabling the patient to see the ink-spot on his own nose, or in a subsequent observation some distant object behind him which has been pointed out to him before taking his seat. This arrangement enables the observer, whilst the patient is accommodating his eyes for different distances, to make the usual test for squint by means of the ruler, held in the right hand, and used alternately to cover the right and left eye. Meanwhile, the ribbon placed behind the patient's ear measures the

distance from the eye to the looking-glass, *i. e.*, half the distance for which the eye is accommodated, if the ink-spot is looked at.

Each eye is covered and uncovered frequently. The patient will sometimes keep on converging at first, and only after several coverings and uncoverings does the innervation of the covered eye give way, and the eye enter into what might be termed the relative position of rest. The relative position of rest is determined at three distances: six meters or more, fifty centimeters, and thirty centimeters, and it is noted whether there is convergence or divergence, and whether the angle of convergence or divergence be large or small.

The determination, thus, of the position of rest at various distances, shows that in viewing a near object convergence does not continue unless required, and the covering up of one eye would normally cause relative divergence. At a distance of thirty or fifty centimeters, deviation of the covered eye must occur in a very slight degree; considerable deviation indicates want of convergence power, which is clinically important when binocular vision exists. Insufficiency of convergence can thus be excluded or diagnosticated without difficulty.

EXPERIMENTS ON THE LYMPH-STREAMS AND LYMPH-CHANNELS OF THE EYE.

Dr. H. Gifford, of Omaha, Neb. (*Arch. of Ophthalmology*, April, 1892), has given the results of experiments which he has made to determine the paths by which the chambers and larger lymph-spaces of the eye communicate with each other and with the parts external to the eye, and they are so instructive that a brief summary of his paper is hereby submitted to the readers of the Journal.

His experiments have been in progress since 1886, and have been made with various substances and by various methods, upon both living and dead animals. The substances principally used were ferro-cyanide of potassium, fluorescein, pigment, and anthrax bacilli. He describes the methods and conclusions of Memorsky, Knies, Weiss, Ulrich, and Stilling, by which solutions of ferro-cyanide of potassium are introduced into the living eye, the eye enucleated, and the ferro-cyanide precipitated by placing it in a ferric chloride solution, the blue color of the precipitate thus produced showing the tissues into which it has been carried during

life. He also studies the effect of the same substance introduced into the dead eye. He concludes, however, that while the blue lines obtained by the ferro-cyanide method are at first sight very striking, and may, to some extent, be influenced by vital processes, there is no evidence to show that they really follow the paths of normal lymph-streams. His experiments with solutions of fluorescein injected subcutaneously, or into the living vitreus, were not convincing.

He believes the pigments gave the most reliable results. He has used injections into the eye, of india-ink and of cinnabar, suspended in one-half to three-quarters per cent. sodium chloride solution. The cinnabar has the advantage of being less likely than india-ink to cause marked reaction, but the particles are heavier and less easily transported by the lymph-streams. India-ink reaches fine channels, which he has not found demonstrable with cinnabar. In injections, *post mortem*, into the anterior chamber and its outlets, he has obtained the most striking results with asphalt chloroform (fifteen per cent.) and a solution of alkanet in turpentine.

Although he is convinced that the introduction of small quantities of pigment into the chambers of the eye and into the cranial cavity in live rabbits, gives the most trustworthy results as to the paths and directions of the lymph-currents, yet there are decided limitations. He has been inclined to believe that wherever considerable pigment was carried into lymph-channels, apparently without the aid of leucocytes, that it must have been transported by some regular stream; but it has been found that in some channels, especially in the finer ones, the pigment finds its way equally well in precisely opposite directions. The judgment of Leber is thus confirmed as to the caution with which conclusions must be drawn from the presence of pigment in any tissue as to the method of its transport.

After detailing his experiments with pigment, and the bacilli of anthrax, Gifford draws the following conclusions :

1. The ferro-cyanide and fluorescein methods are not calculated to give trustworthy results in determining the physiological currents of the eye. Many of the blue lines, obtained by the former method, represent simply the boundaries between tissue into which the ferro-cyanide has become diffused and that containing none. The lines upon which most stress has been laid can be obtained perfectly well in the dead eye.

2. The view of Stilling, that there is no outlet from the vitreus forward around the lens, is incorrect. The zonula (suspensory ligament of the lens) is freely permeable for solid particles, free pigment being carried regularly from the vitreus into the anterior chamber. It is probable that the fluid secreted by the ciliary processes, posterior to the zonula, divides into two portions, one part passing forward into the posterior chamber, and thence through the pupil into the anterior chamber; the other passing back through the vitreus and out through the central canal of the optic nerve into the tissues of the orbit.

3. There is no evidence of any current passing from the posterior chamber through the iris root.

4. There is no evidence of any current from the anterior chamber through the membrane of Descemet into the cornea, although pigment particles may be taken up from the aqueus by the protoplasm of this membrane. As there is shown to be a free connection for non-diffusible substances between Fontana's spaces and the circum-corneal veins, it is probable that the greater part of the aqueous humor leaves the eye in this way. Other finer lymph-channels lead from Fontana's spaces into the posterior layers of the cornea, into the peri-vascular spaces of the sclero-corneal junction (possibly), into the sclera, choroid, and peri-choroidal space. Whenever these channels communicate with spaces in which there is a lower pressure than in the anterior chamber, they must, on the whole, serve, to some extent, as outlets.

5. Between the retinal-pigment epithelium and the layer of rods and cones is a tolerably well-defined space, from which pigment passes freely into the retina, but not into the choroid, except along occasional penetrating blood-vessels in the neighborhood of the optic nerve.

6. Certain facts, such as the regular passage of pigment and bacilli from Fontana's spaces into the cornea, and the progress of sub-conjunctival hemorrhages in the same direction, together with the impermeability of Descemet's membrane from behind, speak for the nourishment of the cornea from its periphery, although the corneal lymph-stream, if it exists, is very weak.

SYMPATHETIC OPHTHALMIA AFTER CATARACT OPERATIONS.

L. DE WECKER, of Paris (*Annals d'Oculistique*, February, 1892), says that one disadvantage of excising a portion of the iris in cataract extraction is that the capsule-wound and corneal-wound

are left in contact, and the capsule thus becomes entangled in, and united to the corneal cicatrix, whereby irritation is set up in the iris and ciliary body, and sympathetic ophthalmia may follow. Since he has adopted the flap extraction and given up iridectomy, he has not had a single case of sympathetic ophthalmia. During a period of eight years, 1,500 cases were operated upon by a section approximating to that of von Græfe, combined with iridectomy. Among these were five cases of sympathetic ophthalmia. During a subsequent period of twenty-two years, 5,000 flap extractions have been made, with or without iridectomy, with only two cases of sympathetic ophthalmia, which apparently occurred before the adoption of the purely corneal section.

GLAUCOMA AFTER DISCISSION OF SECONDARY CATARACT.

KNAPP (*Archives of Ophthalmology*, April, 1892,) records ten cases of glaucoma following discission of the capsule after "simple" extraction of cataract. These constituted a little more than one per cent. of his cases of extraction without iridectomy. As to its pathogenesis, he says he does not venture any hypothesis. One case recovered under the use of eserine ; others did not. A subsequent iridectomy, at least in acute cases, cured the glaucoma. In most cases it was made upwards with a lance-shaped knife, the incision being somewhat back of the one made for the previous extraction, and not very broad. Iris forceps, even those with teeth projecting downward, failed to grasp the iris, and the latter was, therefore, drawn out with the blunt hook and cut off. A little vitreus always protruded, but caused no ill-effect. Dr. Knapp does not feel inclined, because of one per cent. of glaucoma, to return to the combined method of extraction with iridectomy.

IDIOSYNCRASY cannot be too carefully considered, especially in the administration of anesthetics. Cocaine, locally, is considered practically harmless, yet many cases are reported where fatal results have obtained. In the January number of *La Medicine Contemporaire*, M. Terrier reports a case where thirty-eight centigrammes of the salt, injected into the sac of a hydrocele and soon after withdrawn, was followed in an hour by extreme paleness of the face, dilatation of the pupils, foaming of the mouth, general convulsions, and fatal syncope.

In our own experience, seven and one-half grains of chloral, to a vigorous woman of thirty, repeated in an hour, gave anxious hours of unintermitting artificial respiration. . . .—*Kans. Med. Jour.*

BUFFALO MEDICAL AND SURGICAL JOURNAL

A MONTHLY REVIEW OF MEDICINE AND SURGERY.

EDITORS:

THOMAS LOTHROP, M. D. - - WM. WARREN POTTER, M. D.

All communications, whether of a literary or business character, should be addressed to the managing editor: 281 FRANKLIN STREET, BUFFALO, N. Y.

VOL. XXXI. JULY, 1892. No. 12.

AMERICAN MEDICAL ASSOCIATION AT DETROIT.

THE forty-third annual meeting of this Association, held in Detroit, June 7, 8, 9, and 10, 1892, was one of the most remarkable in its history. The location was a favorable one for a large attendance, and the expectations of the officers in this regard were fully realized. The month of June is an attractive one for such a meeting, and the registration numbered something over 1,100. The invited guests, exhibitors, ladies, and attachés swelled this to an aggregate of fully 1,500 visitors, all of whom the hospitable city of the convention provided for in a most acceptable manner. The Committee of Arrangements and the various sub-committees were kept busy for weeks in preparation for the meeting, and their endurance was taxed in a high degree during the sessions. The social part of the programme was an unusually good one, and the citizens of Detroit who contributed to the pleasure and comfort of the visitors have nothing to regret.

The dinner to the Medical Editors, given by Mr. George S. Davis, at the Detroit Club on Monday, June 6th, was one of the most elegant that has been prepared for that Association.

The exhibit hall was well filled with elegant pharmaceutical, mechanical, and literary productions, and was one of the most satisfactory collections of these several departments that we have ever seen.

Messrs. Parke, Davis & Co. fairly outdid themselves in the royal manner in which they entertained all who visited their great laboratory, which is the most extensive plant of its kind in the world. Especially do we recall the pleasant greeting that was given by the chiefs of their several bureaus, who received and conducted the visitors in groups through their respective departments. Their private fire department was turned out time and time again,

and their military band discoursed agreeable music in the court to hundreds of amazed and gratified people. Whoever inspected this wonderful establishment could not fail to depart with a confidence that this famous house was manufacturing and sending out an elegant line of pharmaceutical preparations, that were just precisely what on their face they claimed to be.

The sections performed an enormous amount of scientific work, as attested by the reading and the discussions of over 400 papers, most of which were of a high order, and will be a substantial contribution to the literature of medicine for the year 1892.

The general meetings were very largely attended, and an unusual interest was manifested in the controversy that arose with reference to the code question, which was revived with all the old fire on the part of some of the leaders of the Association, who are the defenders of the so-called old code. The Association was only prevented from committing itself to its former intolerant attitude on this question by a sturdy phalanx of able men, led by Dr. Dudley S. Reynolds, of Kentucky; Dr. A. L. Gihon, of the U. S. Navy; Dr. Charles A. L. Reed, of Cincinnati; Dr. Lewis S. McMurtry, of Kentucky, and Dr. W. P. King, of Missouri. These were supported by many able coadjutors, whom we have not space to mention. If it is admitted that the old code group triumphed in one respect, namely, in displacing one poor little trustee, it must also be admitted that progress was made in another way that two or three years ago would have been thought impossible. When the American Medical Association proposed the appointment of a high joint commission to treat with the Medical Society of the State of New York on differences which have been well known to exist for a decade, surely something must have happened to change the spirit prevailing in the rank and file which now attend this venerable and ever-to-be venerated medical organization. But more than this, a committee to revise the code of ethics was appointed, which, if it performs its duties in the line and direction that is confidently to be expected, will lead to further progress in the reconciliation of differences that were heretofore thought to be insurmountable. Taken altogether, then, we may affirm that the remark made at the opening of this article is justified, namely, that the forty-third meeting of the American Medical Association, at Detroit, was a remarkable one,—remarkable for progress and improvement in substantial and needed directions.

TOPICS OF THE MONTH.

The Jennie Casseday Free Infirmary for Women, of Louisville, Ky., was formally opened for the reception of patients, April 12, 1892. The object of this infirmary is the treatment of the diseases peculiar to women, and it was founded, is owned and conducted by the order of King's Daughters, in Louisville, Ky. Dr. Lewis S. McMurtry is the attending surgeon, and the patients are placed under his skilful surgical supervision, which has already made an astonishing record of success. At the present writing, there are several patients in the private rooms as well as in the free ward, that have undergone abdominal section, and are already passing towards convalescence and assured recovery. This is, so far as we know, the first institution of this kind organized by the order of King's Daughters, and this appears to us one of the most satisfactory methods of making this noted organization useful to society.

The Board of lady managers of this infirmary is presided over by Miss Jennie C. Benedict, Chairman, and it would be difficult to find a more competent young woman for this responsible and arduous place. A recent visit to the infirmary and a careful inspection of the buildings and grounds warrant us in saying that it is one of the most completely appointed institutions of its kind in this country.

The Food Manufacturers' Association will, as we have heretofore announced, hold an exposition at Madison Square Garden, New York, in October next. The announcement is made that Miss Maria Parloa, the celebrated teacher and authority in the art of cooking, will take charge of that department in the exposition referred to. Miss Parloa will lecture and give practical demonstration in cooking every afternoon during the exposition in the Concert Hall. This, together with the Seidl orchestra, led by Herr Anthon Seidl in person, will prove an attractive feature of the exposition.

Following close upon the announced intention of a number of our philanthropic citizens to establish a cholera infantum hospital in the vicinage of Buffalo, comes now the announcement that a children's hospital, for the care and treatment of sick, injured, and crippled children, has already incorporated. The names of the

incorporators and the Board of Managers we cheerfully give below : The Board of Managers for the first year are Sara L. Truscott, Florence D. Folwell, Ottilie H. Rochester, Elizabeth S. Parkhurst, Martha T. Williams, Margaret L. P. Adam, Kate L. Hamlin, Katherine B. Lewis, and Annie W. Spaulding. The other incorporators are Henry M. Watson, Henry W. Sprague, Bernard Bartow, Frances R. Hunsicker, Sherman S. Rogers, Fannie F. Bartow, Geneva L. Wheeler, Ellen O. Watson, George L. Williams, Susan F. Rumsey, M. B. Folwell, and Harriet C. Williams.

There is no more useful charity than one that has for its purpose the cure of crippled children. We have a tender corner in our heart for anyone who is instrumental in rescuing one of these maimed little sufferers from the jaws of crippled invalidism, and in bringing them into the realms of self-supporting happiness.

The administration of the Health Department of the Port of New York, under Ex-Health Officer William M. Smith, who held the office for twelve years, must have been very satisfactory indeed to all who came in official contact with the health officer, judging from the numerous expressions of gratitude that have come from several sources since the office changed hands. The Chamber of Commerce of the State of New York and the Maritime Association of the Port of New York have passed memorials commending the administration of Dr. Smith, while the shipping men, through the agents of the several steamship lines running to the port, have presented him with a handsome testimonial, in the nature of engrossed resolutions in an album especially designed for the purpose, besides twenty-five water-color sketches, representing ships in mid-ocean, and illustrating the health officer's duties in examining incoming vessels. The resolutions were signed by all the leading owners and agents of the principal steamship lines running into the port of New York.

The Medical Society of the County of Erie signalized the severance of its affiliation with the American Medical Association, which was done by vote of the Judicial Council at Detroit, in holding one of the best meetings, considered from a standpoint of scientific work, that has fallen to its lot in many years. This meeting, held June 14, 1892, was not only one well attended, but its sessions were prolonged beyond the usual hours. The profes-

sion of Buffalo and vicinity were highly favored in having in attendance four or five distinguished men from distant cities, who read papers and participated in the debates. The JOURNAL hopes to present to its readers a full report of this meeting by printing the papers and the discussions in an early number. The guests were one and all united in their praise of Buffalo and the royal treatment they received at the hands of the honorable profession of medicine of the Queen City of the Lakes.

WE TAKE pleasure in directing attention to the advertisement of the Buffalo Medical College. This school will endeavor to furnish its students, the coming session, with clinical instruction in obstetrics. This movement is in the right direction, and shows an appreciation of the important work in the Niagara Medical College, the obstetric clinic of which is inferior to none other in this country. We wish success to the effort, inasmuch as it is a movement too long delayed, but of such vast importance to the student in medicine, that it should receive the encouragement of every friend of the college.

THE election of officers for the Buffalo Academy of Medicine was held Tuesday afternoon, June 21st, at the Y. M. C. A. Lecture-room, and resulted as follows: President, DeLancey Rochester; Secretary, William C. Krauss; Treasurer, Eugene A. Smith; Trustees, J. W. Putnam, A. Dagenais, R. Park. A meeting of the Academy was held in the evening, and the above-mentioned officers duly installed. The interest manifested in the Academy by the professions shows that the project is meeting with all the enthusiasm expected of it.

THE NEW YORK PHYSICIANS' MUTUAL AID ASSOCIATION, in which so many of our readers cannot fail to possess an interest, has reached a point in membership where it will henceforth be able to pay $1,000 upon the death of a member, which is the full limit allowed by the by-laws. A further increase of membership is, however, desirable, because it will serve to reduce the assessments, even though they are now comparatively small, being very much less than that of any other associated membership which has an insurance clause. Doctors are very slow to attend to affairs like these, as compared with other pursuits, but when an associa-

tion offers the advantages and protection that can be obtained by membership in this our New York organization, we are amazed at some of the excuses offered for not uniting with it. Applications may be made to the local treasurer, Dr. W. G. Gregory, 530 Main street, Buffalo, N. Y.

Dr. A. A. Hubbell, of Buffalo, is the fortunate possessor of a complete set of the oldest ophthalmic journal in existence, viz., *Annales d' Oculistique*. It was founded in 1838 by Currier, and continued by Warlomont till his death in 1891. Since then its office of publication has been removed from Brussels to Paris, where it is ably conducted by Valude. It reflects most completely the progress of ophthalmology throughout the world during the past fifty-five years, and has been, and continues to be, a powerful factor in promoting the scientific advances in this department of medicine. The set which Dr. Hubbell has been so fortunate to obtain has the additional interest of having belonged to the late Dr. Warlomont himself, who for half a century was its distinguished editor.

The American Medical Association, at its recent meeting in Detroit, adopted a resolution, introduced by Dr. Charles A. L. Reed, of Cincinnati, looking to the annexation of Canada, at least the medical portion thereof, to the United States. In other words, should this amendment to the by-laws prevail, the Dominion of Canada will be embraced in the jurisdiction of the American Medical Association, and we may soon expect to see the Canadian profession walking arm-in-arm with our own down the aisles at the meetings. At the Detroit meeting, many distinguished physicians from Canada attended by invitation, and took part in the work of the sections. It looks as though they would soon take their places as members, with all the rights and privileges pertaining to those from the United States, to which they will assuredly be very welcome.

With this July number the Journal closes Volume XXXI. We present herewith a comprehensive index, which we hope our readers will carefully examine. It exhibits a résumé of our work for the year, and we submit it in the hope that it will merit their approval and bring to us further aid and comfort in the conduct of our difficult and painstaking enterprise, in the way of new subscribers

and encouraging words. For the future, we can only say that we expect to maintain the JOURNAL on the basis of its present lines, and to improve it from time to time, as fast as our increasing patronage will permit.

AT THE National Conference of Delegates of the State Medical Examining and Licensing Boards, held in Detroit, June 8 and 9, 1892, a permanent organization was effected. Dr. William Perry Watson, chairman of the committee, reported a constitution and by-laws, which were considered and adopted with some minor modifications, and the following officers were elected for the ensuing year, namely: President, Dr. John H. Rauch, of Chicago, Ill.; Vice-President, Dr. William Warren Potter, of Buffalo, N. Y.; Secretary and Treasurer, Dr. Hugh M. Taylor, of Richmond, Va. It is intended to hold annual meetings of this organization in connection with the regular meetings of the American Medical Association, with the hope of bringing the different medical examining and licensing boards into closer relation, and to exchange views and opinions that have grown out of the accumulated experience of the past, as well as to promote and encourage the organization of similar boards in states where they do not exist.

Personal.

DR. A. J. MARTIN, of Clarence, N. Y., has gone abroad for a year to study in foreign universities.

DR. WILLIAM EASTERLY ASHTON, formerly Lecturer on Gynecology at Jefferson Medical College, has been appointed Professor of Gynecology in the Medico-Chirurgical College, of Philadelphia, vice Montgomery, transferred to Jefferson. This is a fitting recognition of one of the brilliant members of the younger school of gynecology that has lately grown up in Philadelphia.

DR. ROBERT TUTTLE MORRIS, of New York, the well-known surgeon, has had conferred upon him at the recent commencement of the Center College, of Kentucky, the degree of A. M., *causa honoris*. This college is one of the oldest and most famous of the southern institutions of learning,— the Alma Mater of the Crittendens,

Breckenridges, Blackburns, Harlins, and others of national renown. The honor in case of Dr. Morris is not only worthily bestowed, but it will be secure.

Dr. Lewis S. Pilcher, of Brooklyn, President of the Medical Society of the State of New York, has gone abroad for a few weeks, and is expected to return sometime during August. It may be expected that Dr. Pilcher will inaugurate the campaign and prepare for the next meeting of the society very soon after his return from Europe.

Dr. Arch. Dixon, of Henderson, was elected President of the Kentucky State Medical Society, at its meeting recently held in Louisville. The Kentucky State Medical Society has an honorable record, is progressive in its methods, and elevates her deserving members to the chair. In the selection of Dr. Dixon for president, she has remained true to her traditions.

Dr. Alvin A. Hubbell has returned from his European trip. During his sojourn abroad, he visited the immense ophthalmic clinics of Moorfields, Royal Westminster Ophthalmic, Royal South London Ophthalmic, and other hospitals of London, Abadie's, Gale-Zowski's, DeWicker's, Landolt's, Quintze-Vinghts, Hôtel Dieu, and others of Paris, and everywhere he went he was most cordially received. He also enjoyed the rare hospitalities at their homes of Dr. Julius H. Mickle, Mr. Power, Mr. McHardy, and Mr. G. Anderson Critchett, of London, Mr. Priestly Smith, of Birmingham, and Dr. E. Meyer, and Dr. Landolt, of Paris.

Dr. T. Haven Ross has removed from his former residence, 344 Ashland avenue, to 269 Franklin street, where he will limit his practice to the treatment of diseases of the skin, including removal of hair and cutaneous growths by electrolysis.

Mr. William Dean Howells, editor of the *Cosmopolitan*, whose portrait appeared in the June number of the Journal, intends spending his summer in a quiet nook in New England, devoting a large portion of his time to the writing of his novel of American Girl-Life, to be published in the autumn in *The Ladies' Home Journal.*

Miss Jessamy Harte, daughter of Bret Harte, will make her literary début in the July *Ladies' Home Journal* with a most entertaining description of Camp Life in the Adirondacks, in which it is claimed every evidence shows itself of inherited literary tendencies not unlike those evidenced in her father's earlier work. Miss Harte is a girl still in her 'teens, and has artistic as well as literary proclivities, as one of the illustrations accompanying her first article shows.

Dr. Charles G. Stockton, of Buffalo, was elected chairman of the Section of Medicine, at the recent meeting of the American Medical Association, at Detroit.

Society Meetings.

The eighteenth annual meeting of the American Neurological Association was held at the New York Academy of Medicine, June 22, 23, and 24, 1892. Among the papers read were those by Dr. J. W. Putnam, of Buffalo, on Sleep Movements of Epilepsy, and by Dr. Wm. C. Krauss, of Buffalo, on The Use of Exalgine in Painful Nervous Affections, and another on Two Cases of Severe Pressure Neuritis.

The Medical Association of Central New York held its twenty-fifth annual meeting at Syracuse, Tuesday, May 31, 1892. In point of numbers present and high character of the papers read, it was one of the most successful meetings in its history. Dr. A. A. Hubbell, of Buffalo, N. Y., was its president, and delivered an interesting address on the Abuse of Voluntary Medical Charities. Other papers were read by Drs. Mynter, Ingraham, Stockton, and Putnam, of Buffalo. Papers read by title were those of Drs. Rochester, Thornbury, Crego, and Krauss. Among the Buffalo physicians present were Drs. Hubbell, Ingraham, Stockton, Putnam, Preis, Ring, Krauss, Congdon, Renner, Wende, Jones, VanPeyma, Mynter, and Thornbury.

Mrs. Callahan: "Oi want ter git a pair o' shoes fer the little bye."

Clerk: "French kid?"

Mrs. Callahan (indignantly): "Indade not. He's me own son, born an' bred in Ameriky."

Obituary.

Henry A. Riley, A. B., LL. B., counselor-at-law, died in New York, June 9, 1892, of heart disease, from which he had long been a sufferer. He has been a contributor to the Journal, and his articles on medico-legal subjects are well known throughout the United States. The *New York Medical Journal* says: "Though a lawyer, he was well known to the medical profession by his contributions to the medical jurisprudence to this and other journals." For two years past he has been compelled to abandon his professional pursuits by reason of his ill-health, and he has devoted his time largely to writing upon medico-legal questions. He developed a special field that had heretofore been unoccupied, which was of service to the medical, as well as the legal, profession in the line that he pursued.

Book Reviews.

Annual of the Universal Medical Sciences. A Yearly Report of the Progress of the General Sanitary Sciences throughout the World. Edited by Charles E. Sajous, M. D., and Seventy Associate Editors, assisted by over Two Hundred Corresponding Editors, Collaborators and Correspondents. Illustrated with chromo-lithographs, engravings and maps. Five volumes. The F. A. Davis Company, Publishers, Philadelphia, New York, Chicago, and London. Australian Agency: Melbourne, Victoria. 1892.

This comprehensive and elaborate series of reference books, known as the Annual of the Universal Medical Sciences, appears this year with unusual promptness. The general plan has not been changed from that of the preceding four issues, but it is in every way up to the highest standard of excellence that was fixed at the outset, and each year, the present being no exception, has witnessed an improvement in the details. The associate editors have been carefully chosen with especial reference to their fitness for the work that has been placed upon them, and we find very little to be criticised, either in reference to the general plan of the work or with reference to the methods of its execution. We are somewhat surprised to find that two American publishing firms, owning five or six periodical sheets, have steadily ignored the Annual from the first, refusing even to exchange with it, and prohibiting quotations from the columns of its publications. It is difficult to understand the spirit of anti-progress that pervades some quarters even dur-

ing the closing years of the nineteenth century, when all scientific minds are saturated with thoughts of harmony and progress and are attempting the highest ideal. However, the Annual can afford to ignore these petty little annoyances, and look trustingly forward to the future that will assuredly give this great work the place which belongs to it amongst the medical literature of the world.

The liberal spirit that controls the editor-in-chief is evidenced by the following extract from his preface:

> No sheet is too unimportant to merit oversight at the hands of the editorial staff. Each periodical, however small, is the representative of a community, of a section, or of a class, and it would certainly be rash to conclude that not a man among them is capable of contributing a point of value worthy of notice.

We have made this quotation to illustrate the fact that no mistake was made when Dr. Sajous projected and put in operation such a comprehensive scheme as the publication each year of a *résumé* of the literature of the world, grouped into volumes, handsomely bound, beautifully printed, and comprehensively indexed. It is a work that must always be found upon the shelves of teachers and authors, as well as men who are in the habit of writing for journals and societies, together with a large mass of the profession who are always interested in keeping abreast of the progress of events. We have spoken in years past of the valuable nature of this work, and we now wish to reiterate all we have said heretofore in its praise, and to add that the present series, the fifth year of its publication, witnesses a triumph in medical literature that would have been thought impossible to attain a few years ago,—one almost amazing to contemplate in its stupendous nature. The publishers and artists have performed their work in a most satisfactory manner, and should not fail to receive due recognition therefor from all who are interested in seeing and owning good literature in handsome covers.

REPORT ON CHOLERA IN EUROPE AND INDIA. By EDWARD O. SHAKESPEARE, A. M., M. D., Ph. D., of Philadelphia. United States Commissioner. Transmitted to the Secretary of State. Quarto, pp. xxvi.—945. Washington: Government Printing Office. 1890.

In view of the fact that history teaches us that all previous epidemics of influenza have been followed, in the course of a few years, by an epidemic of cholera, the report of Dr. Shakespeare is most acceptable at this time. It is, by all odds, the most complete

work on cholera that has ever been printed in English, and the quality of the work is unsurpassed.

The work is divided into eight chapters, in which are successively treated, The Course of the Last Wide-spread Epidemic of Cholera; The Topography and Demography of British East India in Relation to Cholera; Bacteriological Investigation and Literature; Preventive Inoculation against Cholera; Measures of Prevention, General and Individual; and The Etiology, Pathology, Symptomatology, Prognosis, and Treatment of Cholera, Infectivosa, or Asiatica.

All of these subjects are so well and thoroughly treated that it is impossible to call one more interesting or more valuable than another. The individual taste will be the determining factor here.

Pains should be taken, however, by everyone who reads this book to spread far and wide the opinion of so fair and unprejudiced an observer as Dr. Shakespeare in regard to the preventive inoculation of Dr. Ferrán. This opinion is quite contrary to that expressed by the other foreign commissioners, who seem to have investigated in a most unfair manner, in a spirit antagonistic to Dr. Ferrán, and, therefore, likely to cause a prejudiced and unreliable report.

Dr. Shakespeare says, among other things:

After having read so much, in the current literature of the day, about the ignorance of Dr. Ferrán of the modern methods of research among bacteria, and of his inability to make decent microscopic preparations, and of his absolute ignorance of the method of staining, I confess that it was with some surprise that I witnessed the facility with which he performed all these operations,—a facility which indicated the *habitual* practice of no mean skill in the performance of these somewhat delicate operations,—and my astonishment was great when, for the first time, I examined with his Hartnack microscope one of the cover-glass preparations which I had seen him make. Honesty and regard for fair dealing require me to say that if there are more beautifully stained microscopic preparations of bacteria, especially of the comma-bacillus of Koch, and of the Finkler and Prior bacillus, anywhere in Europe, I have never seen them. . . . . Prepared to find the characteristics of a charlatan, I met with nothing in the several interviews which I held with Dr. Ferrán which suggested anything of the kind. I found him to be a quiet, reserved, courteous, intelligent, and generally well-informed physician. The impressions which I formed of his theoretical knowledge of bacteria, and of the modern methods of research in the field of natural history, have compared very favorably

with those of most of the leading bacteriologists with whom I have come in contact.

After reviewing carefully the official reports, he concludes:

It would seem, therefore, from careful analysis of the official statistics, that the practice of the anti-choleraic inoculation, after the method of Ferrán, besides giving the subject inoculated a considerable immunity from attack and death by cholera, furnishes a means of bringing an epidemic rapidly to an end.

In the chapter on Measures of Prevention, General and Individual, a most thorough review of the subject, from all points, is given, and practical measures for national quarantine and individual prophylaxis are presented.

In the last chapter, the section on Treatment naturally attracts us most. It begins with the statement that

Knowledge of efficient methods of treatment of cholera infectivosa has by no means kept pace with that of the etiology and prophylaxis of the disease. Unless the so-called methods of hypodermoclysis and enteroclysis shall prove as effective as the recent experience of some Italian observers would seem to indicate, there appears to have been no marked advance made in the therapeutics of severe attacks of cholera. . . . . Whilst this is true of severe attacks of cholera, nevertheless there is scarcely any grave disease which is more manageable, if it be properly and promptly treated during the earlier stages.

The best methods of treatment are then reviewed, and two full pages are given to descriptions of the methods of treatment known as enteroclysis and hypodermoclysis. These methods seem rational, and are certainly worthy of trial. Cantani, the Italian physician, who introduced these methods of treatment, says:

The physician who knows how to use, with courage and reliance, laudanum, tannic enteroclysis, warm baths, and hypodermoclysis, will have to record among the victims of cholera only those unfortunates who, when he was called, were already well advanced in the stage of cyanosis and collapse.

A number of maps, diagrams, and charts, illustrating various matters treated of in the text, add greatly to the value of the work, which is made in every respect convenient for reference by the addition of a most exhaustive index. Dr. Shakespeare is deserving of the highest praise for the thoroughness of his work; the medical profession is to be congratulated that so able and worthy a representative was chosen for this important task, and President Cleveland is to be thanked for the excellent choice that he made.

DEL. R.

THE PRINCIPLES AND PRACTICE OF MEDICINE. Designed for the Use of Practitioners and Students of Medicine. By WILLIAM OSLER, M. D., Fellow of the Royal College of Physicians, London, Professor of Medicine in the Johns Hopkins University, and Physician-in-Chief of the Johns Hopkins Hospital, Baltimore. Formerly Professor of the Institutes of Medicine, McGill University, Montreal; and Professor of Clinic Medicine in the University of Pennsylvania, Philadelphia. New York: D. Appleton & Co. 1892.

Departing from the usual custom of dividing his book into chapters, Osler, without introduction and with only a small prefatory note, commences at once with his subject, and introduces us to his work, made up of eleven sections, by first considering specific infectious diseases. These are considered in thirty subsections, occupying 269 pages. In view of the recent investigations concerning tuberculosis, it is probable that what Osler has to say on this subject will attract much attention. Singularly enough, however, he dismisses the investigations of Koch in a very short paragraph, during the course of which he says, "It will probably be several years before we can speak with decision upon the true position of this remedy," but quotes Schede as saying that it has very positive value in tuberculous arthritis. Osler is very direct and positive in his assertion that the outlook in tuberculosis depends much upon the digestion. This disease has so long been considered from the standpoint of malnutrition, and has been recorded as a malady of decided tendencies to retrograde tissue metamorphosis, that we have come to look upon the care of the digestive tract as one of the principal avenues to improvement, especially in the early stages of this disease. Given a digestive tract that refuses to assimilate hydro-carbons, and it is almost impossible to obtain benefit from any kind of treatment. We are in accord with Osler in his estimate of arsenic as one of the most satisfactory general tonics that can be administered in tubercular disease.

In section two we find constitutional diseases considered in twelve sub-sections. We are much interested in what this author has to say on the subject of rheumatism, because we find so many sufferers from this disease, either real or imaginary, true or false, —acute, chronic, articular. We must confess that we have not been able to draw any new inspiration from Osler's handling of the subject. It is a popular notion among the profession that cardiac complications are very apt to follow in the trail of acute rheumatism. One would suppose, from the shallow treatment of the subject by Osler, that this was of very little consequence as a possible complication, not often to follow and still less often to be of

dangerous portent. One of the most interesting chapters in the practice of medicine that we have lately seen is the section here devoted to diseases of the digestive system, under ten sub-divisions, where one will find the several diseases of the mucous, serous, and glandular system most ably considered. Diseases of the tonsils are always full of professional interest, since these cases are so frequent, manifested either in an acute or chronic form, and a physician will often build his reputation on the prompt relief of the one variety or the other of this distressful malady.

We are finding ourselves more and more in accord with Osler when he says, "If the tonsils are large, and the general state is ever influenced by them, they should be at once removed." In our early professional life we came to this opinion, but later the more conservative view was unfolded to our vision, and we thought the operation of tonsillar excision almost absolutely unnecessary; now, however, after more mature observation and experience, we are inclined to coincide with Osler's opinion in the sentence just quoted.

Diseases of the stomach are justly demanding and obtaining more consideration, more study, more analysis, and more satisfactory handling than ever before. Osler handles these diseases as satisfactory, perhaps, as possible in the limits that he allots to their consideration, and he is especially pointed in some of his asseverations, but we are unable to gain therefrom much knowledge as to the management of so-called dyspepsia, which may be either new or striking in its character. Osler follows Leube with considerable closeness in reference to the ingestion of the foods that are permissible in the several forms of stomach disease.

The diseases of the respiratory system are next considered in five sub-sections, and this is, perhaps, as attractive as any part of Osler's book. We cannot, in the space that we find ourselves necessarily limited to, give an analysis of the several diseases treated of, but we have read carefully what Osler has to say relating to nasal and autumnal catarrh, hoping that we might receive some hint that would enable us to estimate as to the value of the writings of rhinologists on this subject. Osler gives credit to Roe, of Rochester, *inter alia*, for his investigations on the subjects of hay fever, and particularly does he credit Daly, of Pittsburgh, with the discovery of the fact that, in a large proportion of the cases of hay asthma, there is local disease of the mucous membrane of the

nose. There can be no doubt that numerous asthmatic and other deep-chest symptoms are in reality reflexes of nasal or pharyngeal disease, and we wish that Osler had given us some new light on this point, which, in our opinion, is one of the most interesting branches of the subject.

Pleurisy is interestingly handled by Osler, although, in view of the fact that this is an exceedingly common disease, and especially are its sequelæ frequently overlooked, we believe that more complete justice might have been done the subject.

Section five considers diseases of the circulatory system, and the two branches thereof of chief importance, namely, endocarditis and valvular diseases, are handled with much address and great satisfaction. We commend these two sub-sections to every teacher of internal medicine, and especially to the expert in diseases of the chest.

The diseases of the kidneys are treated of in section seven, and here again, on some points, Osler is especially direct and satisfactory. The practitioner will find much here to read with care and to ponder over.

Section eight is devoted to the discussion of nervous diseases, section nine to diseases of the muscles, and section ten to the intoxications. Under section eight are included, (1) diseases of the nerves, (2) diseases of the spinal cord, (3) diseases of the brain, (4) general and functional diseases, and (5) vasomotor and trophic disorders—or, in other words, diseases of the nervous system proper. Generally, authors have included the muscular diseases and the intoxications under nervous diseases, but Osler very wisely separates them. Although the discussion of these subjects must be brief, they are, nevertheless, very compact and comprehensive. Osler's classification and order is excellent, and therein lies the value of a text-book.

Under papillitis the author says it is present in over ninety per cent. of intracranial tumors, and that it is not due to pressure, as many suppose, but to a descending neuritis. The treatment of the various affections is honest and conservative, considerable importance being laid upon the rest treatment. The quotations of many American authors forms a pleasing part of these sections.

The remaining sections of this work — IX., X., XI.,— deal with diseases of the muscles, intoxication, sunstroke, obesity, and diseases due to animal parasites, respectively. A comprehensive index of twenty-eight pages closes the volume. It is one of the most

important contributions to the literature of the principles and practice of medicine that has appeared from an American author for many years, and will, undoubtedly, assume a permanent place on the list of college text-books in the very near future. The publishers have executed their work in excellent taste, and are to be commended for their enterprise in putting it forth at a time when so much literature is being sent out and the risks of text-book publication are very great.

HISTORY OF THE CIRCUMCISION FROM THE EARLIEST TIME TO THE PRESENT. Moral and Physical Reasons for its Performance, with a History of Eunuchism, Hermaphrodism, etc., and of the Different Operations Practised upon the Prepuce. By P. C. REMONDINO, M. D. (Jefferson), Member of the American Medical Association; of the American Public Health Association; of the San Diego County Medical Society; of the State Board of Health of California, and of the Board of Health of the City of San Diego; Vice-President of the California Medical Society, and of the Southern California Medical Society, etc. Number 11 in the Physicians' and Students' Ready Reference Series. Small 8vo, pp. 346. Philadelphia and London: F. A. Davis. 1891.

The value of this book as an addition to our medical literature must largely depend on the spirit in which it is received by the profession. The leading idea of the hygienic effect of circumcision, under certain circumstances, has been recognized in all ages, and there has not been wanting those even among the uncircumcised who have seen in its wise provisions, under climatic and other conditions obtaining in the Orient, the hand of Providence himself. Moses certainly was a wise legislator, by whatever influence guided, and his rules for the physical well-being of his charge leave little room for improvement, even in our own scientific age. This may be conceded, however, without admitting the full claim of the learned writer as to the propriety of circumcision under all ordinary circumstances, and that its omission is attended with danger and even dire results. Remondino is apparently an enthusiast in favor of his theory, and in his eagerness to establish his point scarcely hesitates to refer nearly all the ills of man's moral and physical nature to neglect in adopting his favorite remedy. We think he claims too much of immunity from disease for those who practise circumcision as a rite; it may be true that the Jewish race are physically stronger than those who are called Christians, and it may even be true that circumcision is a factor in their favor, but if it be, we think it is too small a one to count for much among the many

others that might be found by careful and unbiased investigation. The prepuce is particularly blamed for a large class of nervous disorders, and numerous cases are cited which seem to indicate that this is not without foundation, but the propriety of a surgical operation as a prophylaxis, in the absence of any indication or symptom, would seem, from a surgical point of view, to be an officious proffer of assistance to Nature when she has not called for help. Notwithstanding these objections, the book must be commended for the exhaustive treatment of the subject. The many important hints and suggestions which it contains, and the history of the various modes of operation practised from the remotest historic times to those in vogue among the most learned surgeons of our time, make it a valuable addition to the library. Copious notes and a good index finish the volume.

TRANSACTIONS OF THE AMERICAN SURGICAL ASSOCIATION. Volume the IX. Edited by J. EWING MEARS, M. D., Recorder of the Association. Pp. xxxii.—508. Philadelphia: Printed for the Association, and for sale by William J. Dornan. 1891.

This volume is the record of the work of this celebrated association done in Washington at the second triennial Congress of the American Physicians and Surgeons. It was to be expected that under the guidance of its distinguished president, Dr. Claudius H. Mastin, of Mobile, the scientific excellence of this volume would be at least equal to any which the society has issued. Whoever will carefully examine its pages will easily come to the conclusion that this high expectation has been more than realized. The papers, for the most part, have been published in abstract in the journals, and, consequently, need not be dealt with *seriatim* in this notice. We cannot, however, let the opportunity pass to commend the most excellent address of the president, which we listened to with profound interest, and whose eloquent words are still ringing in our ears. His recommendation that a statue be erected to the memory of the late Dr. Samuel D. Gross, has taken root and assumed a fixed and determined form. A circular has been issued to the profession, and the proper committees have been appointed to put the matter in the way of accomplishment.

The first scientific paper in the book is by the late Dr. D. Hayes Agnew, on the Present Status of Brain Surgery, and is a scholarly and able analysis of the work done in that special line by the surgeons of Philadelphia. Dr. Nicholas Senn presented the subject of Treat-

ment of Tuberculosis of Bones and Joints by Parenchymatous and Intra-Articular Injections. This, and the paper by Dr. White on Surgery of the Spine, attracted much attention, and led to valuable discussion. Dr. Albert Vander Veer, of Albany, presented an exhaustive paper on Retro-Peritoneal Tumors, that deserves to be carefully read by every abdominal surgeon. The final paper of the volume, by Dr. George Ryerson Fowler, on Aseptic Operative Technique, is a careful *résumé* of this subject, and contains many points of interest, because of their originality. We close by saying, as we began, that this is one of the most excellent of the many good volumes that this association has issued.

PYE'S SURGICAL HANDICRAFT. A Manual of Surgical Manipulations, Minor Surgery, and other matters connected with the work of House-Surgeons and Surgical Dressers. With 300 illustrations on wood. First American, from the third London edition. Revised and edited by T. H. R. CROWLE, F. R. C. S., Surgical Register to St. Mary's Hospital; and Surgical Tutor and Joint Lecturer on Practical Surgery in the Medical School. Complete in one volume. New York: E. B. Treat, 5 Cooper Union. 1892.

This work is intended primarily for house-surgeons and dressers, and it is for this very reason that it is a valuable addition to the surgical library. It takes up so many little points that the more pretentious works on surgery pass over and leave to the understanding of the reader, that it must prove of great benefit to those practitioners who have not had the advantage of hospital training, and to whom, therefore, the larger books do not convey the definite and precise information so essential in obtaining good results. The author takes up hemorrhage, to which he devotes several chapters. The especial kinds of hemorrhage and the treatment of each are accurately and fully described, and form one of the most valuable sections of the book. The sections also upon bandages, splints, etc., and fractures, are explicit, and their value much increased by numerous illustrations. Sections on wounds, ulcers, burns, etc.; on cases requiring prolonged or mechanical treatment; on surgical and general emergencies; on anesthetics; on extraction of teeth and ear diseases; on minor surgery and kindred subjects, and on preparation of patients for operation and their after-treatment, making of poultices, fomentations, etc., and surgical case-taking, with an appendix containing an excellent formulary, complete the volume and form a collection of topics of special value to the medical practitioner. The wood-cuts, some 300 in number,

are of standard excellence; the type is clear, and the general arrangement of the book good. The marginal notes are very convenient and save much time in getting at the contents of a page.

J. P.

Lectures on Tumors from a Clinical Standpoint. By John B. Hamilton, M. D., LL.D., Professor of Principles of Surgery and Clinical Surgery, Rush Medical College, Chicago; Professor of Surgery, Chicago Polyclinic; Surgeon, formerly Supervising Surgeon-General, United States Marine Hospital Service; Surgeon to Presbyterian Hospital, Chicago; formerly Professor of Surgery in Georgetown University; Surgeon to Providence Hospital, etc., etc. For the use of the Students. Second edition. The Physicians' Leisure Library. Price, cloth, 50 cents; paper, 25 cents. Detroit, Mich.: Geo. S. Davis. 1892.

The appearance of the second edition of this valuable little book within a twelvemonth from the first issue, attests the value and usefulness of the volume in a manner far more substantial than a mere description of the book. The author has taken occasion to correct some of the typographical faults of the first edition, and also to eliminate some of the incongruities that were due to imperfect proof-reading and hasty preparation. We expressed our opinion of this book in unmistakable terms in No. 4, Vol. XXXI., of the Journal, and see no reason to change our opinion after a more mature consideration of the subject and a further examination of this second edition. We believe that it will be accepted by the profession as a valuable addition to the literature of the subject on which it treats, and shall not be surprised to find further editions called for in a reasonable time.

Transactions of the American Association of Obstetricians and Gynecologists. Volume IV. For the year 1891. Standard octavo, pp. xlvi.—320. Philadelphia: William J. Dornan, Printer. 1892.

This handsome volume comprises the proceedings of this prominent Association, held at the Academy of Medicine in New York, September, 1891. The papers, for the most part, are of a superior order, and the discussions upon them are exceedingly strong. It is a kind of work that must give stimulus to medical societies all over the land, and should be read by every physician interested in the progress of obstetrics, gynecology, and abdominal surgery, no matter whether he poses in the attitude of a specialist or not. The volume before us is handsomely illustrated with numerous wood-cuts and process plates, which give an artistic touch to the

subjects that they elaborate, and facilitate a clear understanding of the text. The next meeting of this Association is announced to be held in St. Louis, September 20, 21, and 22, 1892, and we may confidently expect another admirable volume as the result of that meeting.

TRANSACTIONS OF THE NATIONAL ASSOCIATION OF THE RAILWAY SURGEONS. Held at Buffalo, N. Y., April 30 and May 1, 1891. With a Historical Sketch of the Association, List of Members, and other Matters Relating to the Association. Illustrated with portraits of the officers of the association and others. Published by the *Railway Age and Northwestern Railroader*, Chicago, Ill.

This volume is a record of the proceedings of this association at its fourth annual meeting, held in Buffalo, April 30 and May 1, 1891. The scientific papers read at the meeting, have heretofore been published either in abstract or as a whole in the several journals, so that the profession has already obtained a knowledge of the work done at the meeting and the value thereof. The growth of this association has been somewhat phenomenal, comprising now about 1,200; whereas, at the Buffalo meeting the membership numbered in the vicinity of 300. This book is handsomely printed, and contains many portraits of the members of the association, but we may express the surprise where we see so much material to draw from, that there should not be more scientific value to the illustrations and less of the personal element.

BOOKS RECEIVED.

Transactions of the Southern Surgical and Gynecological Association. Vol. IV. Fourth session. Held at Richmond, Virginia, November 10, 11, 12, 1891. Published by the Association. Philadelphia: Wm. J. Dornan, Printer.

Proceedings of the Philadelphia County Medical Society. Vol. XII. Session of 1891. T. B. Schneideman, M. D., editor. Philadelphia: Printed for the Society. 1891.

Manual of Skin Diseases, with special reference to diagnosis and treatment, for the use of students and general practitioners. By W. A. Hardaway, M. D., Professor of Skin Diseases in the Missouri Medical College and in the St. Louis Post-Graduate School of Medicine; Dermatologist to the Augusta Free Hospital for Children; Consulting Dermatologist to the City and Female Hospitals; Ex-President of the American Dermatological Association. Philadelphia: Lea Brothers & Co. 1891.

U. S. Department of Agriculture, Division of Chemistry. Bulletin No. 13. Foods and the Food Adulterations. Investigations made under direction of H. W. Wiley, Chief Chemist, with collaboration of

H. A. Huston, H. H. Nicholson, W. B. Rising, M. A. Scovell, S. P. Sharples, W. C. Stubbs, Shippen Wallace, F. G. Weichmann, H. A. Weber, and K. P. McElroy. Part sixth. Sugar, Molasses and Syrup, Confections, Honey and Beeswax. Published by authority of the Secretary of Agriculture. Washington: Government Printing Office. 1892.

U. S. Department of Agriculture. Division of Chemistry. Bulletin No. 32. Special Report of the Extent and Character of Food Adulterations, including State and other Laws Relating to Foods and Beverages, by Alex. J. Wedderburn, Special Agent. Published by authority of the Secretary of Agriculture. Washington: Government Printing Office. 1892.

Bureau of Education. Circular of Information No. 9, 1891. Biological Teaching in the Colleges of the United States, by John P. Campbell, A. B., Ph. D., (Johns Hopkins,) Professor of Biology in the University of Georgia. Washington: Government Printing Office. 1891.

Bureau of Education. Circular of Information No. 5, 1891. Contributions to American Educational History, edited by Herbert B. Adams. No. 12. The History of Higher Education in Ohio. By George W. Knight, Ph. D., Professor of History, Ohio State University, and John R. Commons, A. M., Associate Professor of Political Economy, Oberlin College. Washington: Government Printing Office. 1891.

A System of Practical Therapeutics. Vol. III. Edited by Hobart Amory Hare, M. D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia; assisted by Walter Chrystie, M. D. In three volumes, comprising 3,544 pages, with 434 illustrations. Per volume, cloth, $5.00; leather, $6.00; half Russia, $7.00. Sold by subscription only. Philadelphia: Lea Brothers & Co. 1892.

Miscellany.

THE LAW GOVERNING THE PRACTICE OF MEDICINE IN NEW YORK STATE AND HOW IT IS ENFORCED.

The many inquiries directed to the Regents' office and to the secretaries of the various State Boards of Medical Examiners, indicate that the profession is largely interested in the operations of the law at present governing the practice of medicine in the State of New York. This manifested interest is accepted as of sufficient moment to warrant the publication of the salient features of the law, and, at the same time, to give the profession an insight into the methods and machinery necessary to its proper enforcement. The law, signed by the Governor June 4, 1890, went into effect September 1, 1891, and has been operative since that time. It provides: "From and after the 1st day of September, 1891, any person not theretofore lawfully authorized to practise medicine and surgery in this State, and desiring to enter upon such practice," may, after the following conditions have been fulfilled, receive an order to be examined before one of the three State Boards of Medical Examiners as to his medical qualifications. 1. Applicant must be more

than twenty-one years of age. 2. Must present certificate of moral character from two legalized resident (State) medical practitioners. 3. Must be a graduated doctor of medicine from some legally incorporated medical college in the United States, or have received a diploma or license conferring the full right to practise all the branches of medicine or surgery in some foreign country. 4. Must have attended at least three full courses of lectures, in different years, in some legally incorporated *medical* college or colleges. 5. Must pay $25 into the treasury of the University of the State of New York. 6. Must present evidence of preliminary education as follows: Either *a*, usual academic degree; *b*, one year at academic-degree-conferring college; *c*, three years in a high school or academy; *d*, be in possession of Regents' medical student certificate; *e*, matriculation certificate required by present medical act of Canada; *f*, matriculation certificate from any university in Great Britain or Ireland; *g*, certificate of having passed examinations of any registered institution equivalent to one year in academic college or three years in high school.

All these preliminaries having been complied with, upon proof presented by the applicant, in his or her own handwriting, to the satisfaction of the Regents (on blank forms furnished on application), an order is given admitting the candidate to the next examination. Five regular examinations are held during the year (during the year 1892 there are still three regular examinations to be held as follows: June 14-17, September 27-30, and November 22-25,) simultaneously, at New York City (21 Cooper Union), Albany High School Building, Syracuse High School Building, and Buffalo High School Building, and as many special examinations are ordered as are deemed necessary by the Regents depending upon the exigencies which may arise. At these examinations the candidates are examined on the subjects of—1, Anatomy; 2, Physiology and Hygiene; 3, Chemistry; 4, Surgery; 5, Obstetrics; 6, Pathology and Diagnosis; and 7, Therapeutics, including Practice and Materia Medica. The candidate is allowed three hours' time in which to answer ten from among the fifteen questions submitted on each topic; each answer, if correct, has a value of ten points, and *each* full paper of ten questions answered must have a total value in markings of at least seventy-five points, otherwise the candidate is rejected. There are two sessions of three hours daily; each session devoted to one of the seven topics; thus, three and one-half days are requisite for completing the examination. The candidates are examined according to number, no name being allowed to appear on the answer papers; the name of the candidate is placed in an envelope marked with the corresponding number, is sealed, and left unopened until the final report of the examiners has been made.

There are three boards of State Medical Examiners, as follows: representing the Medical Society of the State of New York, Homeopathic Medical Society of the State of New York, and the Eclectic Medical Society of the State of New York.

Medical Society of the State of New York.—Physiology and Hygiene, William C. Wey, M. D., *President;* Chemistry and Materia Medica, Maurice J. Lewi, M. D., *Secretary*, 71 Lancaster street, Albany; Anatomy, William S. Ely, M. D.; Surgery, George Ryerson Fowler, M. D.; Obstetrics, William Warren Potter, M. D.; Pathology and Diagnosis, J. P. Creveling, M. D.; Theory and Practice and Therapeutics, Eugene Beach, M. D.

Homœopathic Medical Society of the State of New York.—Pathology and Diagnosis, Asa S. Couch, M. D., *President;* Anatomy, Horace M. Paine, M. D., *Secretary*, 105 State street, Albany; Physiology and Hygiene, A. R. Wright, M. D.; Chemistry, John McE. Wetmore, M. D.; Surgery, E. E. Snyder, M. D.; Obstetrics, William S. Searle, M. D.; Therapeutics, Practice and Materia Medica, Jay W. Sheldon, M. D.

Eclectic Medical Society of the State of New York.—Obstetrics, Hugh J. Linn, M. D., *President;* Surgery, Edwin S. Moore, M. D., *Secretary*, Bay Shore; Anatomy, William L. Tuttle, M. D.; Physiology and Hygiene, Robert Hamilton, M. D.; Chemistry, Harry B. Smith, M. D.; Pathology and Diagnosis, John P. Nolan, M. D.; Therapeutics, Practice and Materia Medica, *Vacancy.*

They are appointed by the Regents from nominations submitted by the State, Homeopathic, and Eclectic Medical Societies, for a term of three years, for every vacancy two names being submitted by the societies. The principal work of the examiners is to formulate questions for examination purposes and to mark the answers thereto. The questions submitted at each examination are the same for all candidates, excepting on the seventh topic (Therapeutics, Practice and Materia Medica), three sets of questions being furnished at each examination, each set representing the views of one of the three legally incorporated schools of medicine in the State on this subject, the candidate receiving the set for which he had expressed a wish in his original application for license. The questions to be used at the various examinations are decided upon as follows, those previously secured in a similar way having become exhausted: The Regents issue a notice requesting each of the twenty-one examiners to forward, on or before a certain date, sixty questions on the special topic to which each is assigned; subsequent to this date the Questions Board, consisting of six members, two from each board, is called in session. The questions on the seventh topic are handed to the two members representing their special board, who, as previously stated, and as particularly specified in the law, have complete charge of this subject. With the other six subjects, 180 questions having been submitted in each, the Questions Board acts as follows, taking Anatomy, for instance: The secretary reads a question alternately from each of the three papers submitted by the examiners in this topic, and unless each receives the unanimous vote of all present, it is stricken from the list of available questions. The 180 questions having passed through this process, are arranged in sets of fifteen, each

set is numbered and sealed, and thus at one sitting, lasting, however, many hours, an average of ten complete sets of questions is prepared, thus providing for ten future examinations. These sets of questions are placed in the custody of the Regents, who, as the time for the next examination approaches, call upon the secretary of the Questions Board to review the printer's work after the questions are put up in type. The examinations proper are conducted by a sworn official of the Regents' office, who is not a member of any one of the State boards of medical examiners. As soon as the examinations are concluded, the answer papers are delivered to the secretary of the board selected by the candidate in his application, and by him in turn sent to the different individual examiners, who return the papers with their markings to the Board of Regents; these answer papers thereupon become a part of the public records of the State. If a favorable report is made by all of the examiners on the answers of any applicant, a license is immediately forwarded to his address, thus enabling him to register at once and commence the practice of his profession. The last examination was concluded May 6th, and on May 14th the licenses were forwarded from the Regents' office to the successful candidates. Arrangements are now being made for the next examination, which will enable the Regents to forward these licenses within five days of the close of the examinations. The income accruing from this law goes to the Board of Regents, who, after paying all proper expenses, will, if ever there should be a surplus, apportion the money among the twenty-one examiners according to the number of candidates examined by each. Graduates in medicine who have been licensed by State examining boards of other States *of the United States only*, on convincing the Board of Regents that the standard of requirements adopted by the board of examiners which granted them the license is substantially the same as in New York State, may, upon the payment of $10, have such license endorsed. The following summary of the laws has been made:

1. The University of the State of New York is the only organization having authority to issue licenses to practise medicine in this State after September 1, 1891. These licenses must be registered by county clerks on application. (*Laws of New York*, 1890, ch. 507, § 8–9.)

2. Licenses issued before September 1, 1891, can be registered only as follows: *a*, A diploma granting the degree M. D., issued before September 1, 1891, by an incorporated medical college *in this State*, is a license to practise medicine and must be registered on application. (*Laws of New York*, 1889, ch. 647, § 2.)

b. A diploma granting the degree M. D., from a medical college *out of the State*, or a license to practise medicine in some foreign country, can be registered only if it was endorsed between June 18, 1880, and June 24, 1890, by an incorporated medical college of the State of New York, or by the University of the State of

New York, or if between June 24, 1890, and September 1, 1891, it was endorsed by the University of the State of New York. (*Laws of New York*, 1880, ch. 513, § 4; 1887, ch. 647, § 2; 1890, ch. 500.)

3. Students who had matriculated in a New York State medical college prior to June 5, 1890, and had not received the degree M. D. prior to September 1, 1891, to be exempt, must have filed a certificate with the University of the State of New York before August 4, 1891. (*Laws of New York*, 1891, ch. 311.)

Licenses of such candidates may be registered as follows: *a*, A diploma granting the degree M. D. from a New York State medical college, issued after September 1, 1891, can be registered on presentation of a certificate from the secretary of the University of the State of New York that the applicant had matriculated in some medical college of the State prior to June 5, 1890. (*Laws of New York*, 1891, ch. 311.)

b. A diploma granting the degree M. D. from a medical college not in the State, or license to practise in a foreign country, if endorsed by the University of the State of New York, can be registered on presentation of a certified copy of a certificate filed with the secretary of the University of the State of New York that the applicant had matriculated in some medical college of the State prior to June 5, 1890. (*Laws of New York*, 1891, ch. 311.)

All diplomas issued by medical colleges in this State prior to January 1, 1880, which are presented for registration after this date, should be referred to the University of the State of New York for examination before being registered.

And further, to quote the exact wording of the law:

§ 10. Nothing in this act shall be construed to interfere with or punish commissioned medical officers serving in the army or navy of the United States, or in the United States marine hospital service while so commissioned, or anyone while actually serving as a member of the resident medical staff of any legally incorporated hospital, or any legally qualified and registered dentist exclusively engaged in practising the art of dentistry, or interfere with manufacturers of artificial eyes, limbs, or orthopedical instruments or trusses of any kind from fitting such instruments on persons in need thereof; or any lawfully qualified physicians and surgeons residing in other States or countries, meeting registered physicians and surgeons of this State in consultation, or any physician or surgeon residing on the border of a neighboring State and duly authorized under the laws thereof to practise medicine or surgery therein, whose practice extends into the limits of this State; provided that such practitioner shall not open an office or appoint a place to meet patients or receive calls within the limits of the State of New York; or physicians duly registered in one county of this State, called to attend isolated cases in another county, but not residing or habitually practising therein.

Appended will be found the examination results thus far obtained:

Number of those who fulfilled all requirements and received license	34
Number of applications still unacted upon	10
Rejected for failure to reach seventy-five per cent. at final medical examination	1
Deficient in preliminary education	6
Had never attended three full courses of lectures	4
License withheld because of moral reasons	1
Total number of applicants for license to practise medicine to date	56

Addenda.—All examinations are conducted in English, unless the applicant expresses a desire to be examined in Latin. In that event, the application, with the reasons therefor, is placed before a committee consisting of the presidents of the three boards, whose decision is accepted by the Board of Regents. The candidate must pay the expenses of translation. Whenever it is found necessary to obtain the opinion of the board of examiners, the University authorities are requested to confer with a sub-committee of the conference, consisting of the president and secretary of each board, who are the executive committee of the boards. The boards proper meet twice in each year.

A syllabus is in course of preparation, and will be issued shortly. A candidate having failed, whether in one or all seven branches, his application for license is rejected. On re-examination no fee is exacted, but the candidate must pass the examination on all seven topics, regardless of the number he passed at the previous examination. Appeal for a re-opening of any examinations may be made to the Regents of the University.

Indications point to a class of from fifteen to twenty applicants at the next regular examination, June 14, 1892.

By order of the State Board of Medical Examiners, representing the Medical Society of the State of New York.

WILLIAM C. WEY, *President.*

MAURICE J. LEWI, *Secretary.*

GIRLS WHO HAVE PUSH.—There is an interesting group of bright girls at the New England Conservatory of Music, in Boston, who represent the quality of push characteristic of the American girl. There are some thirty-five of these girls, and they are being musically and vocally educated by *The Ladies' Home Journal* of Philadelphia. Some time ago this magazine offered, as a stimulant to girls to get subscriptions for it, free educations at the Conservatory. The American girl is quick to see a chance, and one by one these thirty-five girls have come from all parts of the country to Boston. They receive the very best the Conservatory affords, the most desirable rooms in the building are theirs, and they have all their wants carefully looked after by a wealthy periodical. Perhaps in no other country on the face of the globe could such a thing be possible. These girls, too, the reporter was told, belong to nice families, but they preferred to earn their own musical education rather

than depend on the family purse. Of course, the particular girls are unknown to the scholars at large, and to all intents and purposes they are paying their own way. And they certainly are. It is said that the magazine is also educating a number of other girls at Wellesley, Smith, and Vassar Colleges.—*The Boston Journal.*

The Hudor Company, of Buffalo, manufactures for the use of the profession a lithia water which contains 41.37 grains of lithium carbonate to a gallon. It is highly charged with carbonic acid, and is an agreeable drink, besides being a useful medicine for the lithemic state and allied conditions. In addition, this company manufactures high grade ginger ale, lemon champagne, and other mineral waters, which they bottle and furnish to physicians and for private use. They also manufacture pure distilled water, which can be obtained by physicians at a very small cost, which is something of an object where a great quantity is required. It is a great advantage to a city to have such a manufactory within its own borders, and physicians should not be slow to manifest their appreciation of the fact.

Never judge an actor by the length of his hair. The property man sometimes has longer locks than the tragedian.—*Buffalo Express.*

Put off the presentation of your bill for a year, and the patient will conclude that your services were worth but little, and that you knew it.—*Ex.*

She found an explanation.—"You see, Mrs. Oilriz," said the suave young man, "they called them 'Canaanites' because they came from Canaan."

"Oh, I understand," said the old lady, affably. "There's something that Mr. Oilriz knowed and I didn't."

"Indeed!"

"Yes. He had heard that you spent several years in Paris, and he spoke of you yesterday "as a Parisite."—*Judge.*

Notice to Contributors.—We are glad to receive contributions from every one who knows anything of interest to the profession. Articles designed for publication in the Journal should be handed in before the first day of the month. The Editors are not responsible for the views or opinions of contributors. All communications should be addressed to the Managing Editor, 284 Franklin St., Buffalo, N. Y.

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Whole Number, CCCLXI.

New Series.

August, 1891.

Vol. XXXI. No. 1.

Buffalo Medical and Surgical Journal.

Established 1845 by AUSTIN FLINT, M. D.

PUBLISHED MONTHLY.

Editors:

THOS. LOTHROP, M. D. WM. WARREN POTTER, M. D.

Associate Editors:

WILLIAM C. KRAUSS, M. D. JAMES WRIGHT PUTNAM, M. D.

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European Agency
TRÜBNER & CO.,
57 and 59 Ludgate Hill, London, E. C.

BUFFALO:
1891.

Foreign
Subscription, $2.50

Entered at the Post-Office at Buffalo, N. Y., as Second-class Mail Matter.

Times Printing House, Buffalo, N. Y.

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